STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165460	A. Building B. Wing	06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Karen Acres Care Center	3605 Elm Drive Urbandale, IA 50322

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review, hospital record review, family and staff interviews, and facility protocol review, it was found that for 1 of 4 residents reviewed for assessment and intervention (Res #3), the facility failed to complete accurate daily assessments; transcribe and administer medications per provider orders; recognize and assess a change in bowel patterns; follow the facility protocol for a bowel regimen; and completely and accurately document fluid intake for a resident on a fluid restriction. The facility reported a census of 29. Findings include:The Minimum Data Set (MDS) Assessment of Resident #3 dated 1/30/26 identified a Brief Interview for Mental Status (BIMS) score of 13 which indicated cognition intact. The MDS reflected the resident to be frequently incontinent of bowel. The MDS documented diagnoses which included heart failure and constipation. The MDS recorded the resident experienced pain during the 5-day look back period and received scheduled and as needed pain medications as well as non-medication pain interventions. The MDS recorded the resident reported she experienced pain almost constantly, frequently interfering with sleep and therapy and rated the worst pain at a 10 on a 00 to 10 pain scale with 10 being the worst pain imaginable. The MDS documented the resident received opioid medication during the 7-day lookback period. The Baseline Care Plan documented Resident #3 had a diet order of regular foods, with a fluid restriction, and also documented the resident to be frequently incontinent of bowel. The Care Plan identified the resident's admission date to the facility to be 1/23/26. The Health Status Note dated 2/9/26 at 9:24 am documented Res #3 had concentrated dark maroon urine in her urinary catheter downdrain bag. The resident was complaining of nausea and had vomited clear dark brown fluid. Her abdomen was described as non tender but distended and the nurse was unable to hear any bowel sounds. Staff A, Registered Nurse, author of the note, also documented the facility Advanced Registered Nurse Practitioner (ARNP) had been notified of the resident's symptoms. The note was updated at 9:35 am that orders were received to send the resident to the hospital. The resident's spouse was notified and the ambulance was in route. The documentation from the Emergency Department of a local hospital noted the resident arrived at the hospital for evaluation of abdominal pain. Her pulse was noted to be 125 per minute (normal 60-90). The note described the resident's abdomen diffusely tender to palpation and soft. Dried emesis (vomit) was around her mouth and she appeared uncomfortable. Lab tests revealed a white blood cell count of 25.3 (normal 4-11, a high reading indicates infection). The testing revealed a concern for perforation of the bowel, the resident was taken into surgery. The Hospital Records with admit date of 2/9/26 documented as follows; Res #3 had a medical history of long term chronic constipation, obesity, sedentary lifestyle, a prior stroke, diabetes, heart failure and chronic kidney disease amongst other chronic conditions. She had additionally recently suffered an acute gallbladder attack resulting in her gallbladder being removed. Two surgeons operated on Res #3 for over six (6) hours creating a colostomy as well as multiple other procedures due to severe bowel impaction and obstruction. The surgery was very complicated and the resident remained hospitalized for ten days as her health worsened and she eventually passed away in the hospital on 2/19/26. A skilled evaluation was completed for Resident #3 daily from 1/25/26 through 2/8/26. On each of these assessments (15 in total), it was documented that the gastrointestinal (gi) baseline had been met. The assessment documented the gi baseline to be (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abdomen flat, non-tender. Bowel sounds present in all 4 quadrants. Resident denied indigestion, nausea, vomiting, diarrhea, constipation, or bowel incontinence. The Documentation Survey Report of Res #3 for January and February of 2026 documented the following for bowel movements:1/23/26 - small bowel movement, incontinent1/24/26 - large bowel movement, incontinent1/25/26 - small bowel movement, continent1/26/26 - small bowel movement, continent1/27/26 - small bowel movement, incontinent1/28/26 - small bowel movement, incontinent1/29/26 - small bowel movement, incontinent1/30/26 - small bowel movement, continent1/31/26 - no bowel movement 2/01/26 - no bowel movement 2/02/26 - no bowel movement 2/03/26 - medium bowel movement, incontinent2/04/26 - medium bowel movement, incontinent2/05/26 - no bowel movement 2/06/26 - no bowel movement 2/07/26 - no bowel movement 2/08/26 - no bowel movement A Communication with Physician note dated 2/2/26 at 6:12 am documented the resident reported feeling constipated. An as needed suppository was administered and was ineffective. The note indicated the resident's bowel log was attached in the fax. No other progress notes were found in the chart indicating any concern for the change in bowel pattern from initially having bowel movements daily to then only twice in nine days. The facility document titled Bowel Movement Management documented an objective of: To provide an effective method to monitor Resident's bowel evacuation and ensure regularity and intervene if concern.The protocol documented:The Certified Nursing Assistance (CNA) documentation form shall include the documentation of the Resident's bowel movements every shift.The night nurse at the end of the shift shall evaluate the BM documentation records and assess for residents with BM irregularity.Residents who have not had a BM in the last three (3) days, shall be placed on a MOM (Milk of Magnesia, a laxative) list and provided MOM.Residents who have not had a BM in four (4) days shall be given a suppository or provider recommendation.If a Resident does not have results from the suppository/provider recommendation the day shift nurse shall assess the Resident, report findings to the provider for further direction/management. The Clinical and Order Alerts Listing Report identified Resident #3 triggered for having had no documented bowel movement for two days on:2/2/26 at 5:25 am2/2/26 at 9:11 am2/2/26 at 8:12 pm2/6/26 at 1:21 pm2/6/26 9:01 pm2/7/26 5:17 am2/7/26 at 9:59 am2/7/26 at 9:01 pm2/8/26 5:14 am2/8/26 at 10:12 am2/8/26 at 8:27 pmReview of the February 2026 Medication Administration Record (MAR) of Res. #3 revealed no as needed (PRN) bowel medications were administered on 2/2/26. However, the resident's record generated three separate alerts on that date indicating no documented bowel movement for greater than two days. The MAR additionally failed to review any PRN medications in response to the two alerts on 2/6/26. The MAR revealed on 2/7/26, after the trigger alerts of 5:17 am and 9:59 am, Milk of Magnesia (MOM) was given at 3:40 pm. The MAR revealed on 2/8/26 after the trigger alerts of 5:14 am and 10:12 am, lactulose was given at 4:52 pm. The facility ARNP documented an acute visit to Resident #3 on 2/3/26 for several complaints. She noted the resident had a lot of constipation which was likely multifactorial. She described the resident as being very sedentary and immobile. She additionally was on a fluid restriction related to cardiac issues. The visit documentation also noted the resident's use of oxycodone (a narcotic pain medication) which can frequently cause opioid induced constipation. The ARNP ordered on this visit to increase Res #3's senna (oral laxative) to two tabs twice daily. She also noted that the resident had as needed lactulose (liquid laxative) orders and advised staff to please use it. She included an (!) mark at the end stating to utilize the lactulose. The ARNP visit note was dated 2/3/26 at 11:29 am. The orders were then noted (a process of review, verification, and recording the provider's orders into the patient's chart) by Staff D, Licensed Practical Nurse. The order audit report documented the Senna increase was placed into the Electronic Health Record (EHR) orders on 2/3/26 at 11:56 am by Staff D. However, the MAR reflected that several hours later, at 3:38 pm, Staff D administered Milk of Magnesia to Resident #3 rather than the lactulose that the ARNP ordered. The MAR further reflected the lactulose was given only one time, on 2/8/26 at 4:52 pm. admission orders dated 1/23/26, following Resident #3's gallbladder surgery, prescribed oxycodone 5 mg tablets on an as-needed basis: half a tablet every four hours for moderate (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain (scale 4-6) and one tablet every four hours for severe pain (scale 7-10). Review of the January and February Medication Administration Records (MAR) revealed that these orders were transcribed into the facility's EHR without documenting the necessary pain scale parameters required for administration. (Based on these orders, if the resident rated her pain between 0-3, no oxycodone should be given). The admission orders additionally ordered a fluid restriction of 1500 milliliters (mls) (50 ounces) a day. The MAR for January and February of 2026 reflected a total of 16 administrations of oxycodone were given between 1/24/26 and 2/8/26. A review of the 16 oxycodone administrations revealed 9 (56%) medication errors where the drug was administered outside of the ordered pain scale parameters. Specifically, on three of those occasions, the resident received the medication despite rating her pain as a three, and on six additional occasions she received the full 5 mg tablet when her pain was rated below a seven. A review of the meal and fluid intake report between 1/25/26 and 2/9/26 revealed that while the percentage of meals eaten was documented, mealtime fluid intake was not documented at all. An order in the EHR specified a 1500 ml (50 ounces) daily fluid restriction, allotted as 350 mls per meal and 100 mls per medication pass (four times a day), totaling 1450 mls per day. However, only the MAR documented the fluids administered during medication passes. The EHR lacked any documentation demonstrating that the resident's total daily 1500 ml fluid restriction was being tracked or monitored. On 6/15/26 at 4:15 pm, the spouse of Resident #3 stated he felt the facility did not provide enough liquids to Resident #3. He described that the resident had suffered from long term constipation and that when she was hospitalized after leaving the facility, a surgeon at the hospital told him that she was completely impacted with bowel. On 6/17/26 at 12:07 pm, Staff A, RN reviewed the note she wrote on 2/9/26 reflecting why the resident was sent into the hospital. She stated they had been having a lot of issues with her bowels and had supplied Milk of Magnesia and suppositories. She recalled that the ARNP had told staff to utilize the lactulose. She stated based on the facility bowel protocol, MOM should have been administered on 2/6 and a suppository should have been administered on 2/7. She said generally a suppository is administered by the night shift and oral laxatives are administered by the day shift. She stated in reviewing the resident notes, she had not documented any concerns the prior days she was working, February 5th and 6th. She stated if she had not documented anything, then she would have had no concerns those days. She felt the resident was fine on Friday 2/6/26 and then when she returned to work on 2/9/26, she didn't know what had happened. She recalled not being able to hear any bowel sounds. When asked what kind of pain the resident normally complained of, she stated she did not recall anything specific, she felt it was generalized pain.On 6/17/26 at 12:45 pm, Staff B, Certified Nurse Aide (CNA) stated she would assist the resident to get up and attempt to use the restroom and she noticed her getting a bit weaker. She recalled Res #3 complained a lot of constipation and that she often drank prune juice at breakfast. She was unable to recall the resident complaining of nausea. She described the resident as not being demanding, but that if something didn't go her way, she would call her husband about it and tell him things were going wrong. She stated she was never asked to assist a nurse in administering a suppository but she did witness staff bring MOM into the room. On 6/17/26 at 1:15 pm, Staff C, CNA stated she recalled Res #3 would often refuse to get up to try to use the bathroom. Or if she did sit on the toilet, she would be pushing and trying to go and get very upset when she could not. She told Staff C that it hurt to push when trying to have a bowel movement. She did not recall ever seeing any blood from her rectum or recall the resident ever vomiting. On 6/17/26 at 3:47 pm, the Director of Nursing (DON) reviewed the resident's bowel record and medications given. She stated she assumed Staff D administering lactulose instead of utilizing a suppository on 2/8/26 (day 4 of no bowel movement) was due to the ARNP directing staff to utilize the lactulose. At 4:20 the same afternoon, the DON stated that while almost all of the resident's bowel movements in January were documented as being small, staff can interpret sizes differently and also stated two mediums were documented in February. She stated the resident cried a lot and did not want to do much of anything, she cried during therapy (physical and occupational therapy). She stated the resident did not complain of bowel (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	issues, but was tearful all the time and complained of pain everywhere, not a specific area. She stated that on the admission orders, she had mistakenly noted d/c (discontinue) on one of the oxycodone orders and stated that was an error and it was not discontinued. She verified the oxycodone order should have been placed into the facility EHR to inlcude the pain scale parameters. On 6/17/26 at 4:32 pm, Staff E, CNA stated she didn't recall the resident very well. She knew she asked for pain medication and she would notify the nurse. She did not recall anything specific regarding her bowels or any complaints of nausea or vomiting. On 6/18/26 at 9:46 am, Staff F, CNA described that Res #3 cried a lot. She recalled her frequently complaining of constipation. She recalled hearing in report one shift the resident had not gone for several days. She stated she thought they had administered MOM. She did not remember anytime after that the resident having any bowel movements. She recalled one shift the resident was vomiting she thought three times in one shift. Reviewing her schedule, she believed this was February 6th. She felt she had reported it to Staff A, RN but could not be sure. She also recalled whenever she would be able to get Res. #3 onto the toilet, she would sit there for a very long time trying to have a bowel movement and wasn't able to. She stated the resident got to the point that she just gave up and didn't even want to try. She stated the resident would ask for the nurse and she would report this to the nurses. On 6/18/26 at 11:06 am. The ARNP stated she would think the staff would have utilized the lactulose she requested they use after 1-2 days of the resident not having a bowel movement but she emphasized they would likely go by their bowel protocol. She stated the resident had plenty of medications available for use and she was not aware of what they did and did not give. On 6/18/26 at 11:20 am, in a second interview with Staff A, she stated she had no recollection of any reports of Res #3 vomiting except the day she sent her to the hospital. She stated if she did not document it, then she didn't remember it but that she always documented anything out of the ordinary so she could pass it on in report. She stated even the smallest amount of emesis, she would chart it so she could not answer to the interview given by Staff F. On 6/18/26 at 1:40 pm, the Director of Rehab (Physical and Occupational therapy) stated he recalled Res #3 being very with it cognitively, she could always answer questions but was always in a lot of pain. He didn't recall a specific complaint of pain location although he thought it might have been back pain. He did recall that her husband did everything for her at home. He was told that for six months or so before arriving at the facility, she mostly just laid in bed. He stated her spouse had told him that he would make her a sandwich or something for meals and leave it for her when he went to work (in a refrigerator in their bedroom). She didn't have to get up and do anything and she was very weak. He stated therapy was able to get her up and walking short distances but not much beyond getting to the bathroom and back. On 6/22/26 at 10:53 am, Staff D, LPN was shown the note from the ARNP stating to increase the laxative daily and to utilize the lactulose. It was verified she had noted the order and updated the senna order into the EHR. When asked why she administered MOM that day instead of lactulose, just hours after receiving the order from the ARNP, she stated the resident had orders for both medications so they could use either. She said she often pours several cups of MOM on the medication cart and will distribute them to multiple residents. She said she would offer the resident whichever medication she preferred. On 6/22/26 at 10:57 am, the DON stated that staff do not document fluid intake at meals, noting they only document the percentage of the meal eaten. She stated that for as long as she had worked at the facility, daily fluid intake has never been documented, except on the MAR during medication passes for residents on fluid restrictions. The DON explained that for residents on fluid restrictions, the permitted fluid amount is printed on the dietary tray ticket so staff know how much to provide with each meal. She added that if dietary trays were being collected and Res #3 had not finished her fluids, staff would offer for her to keep them. She stated Res #3 would generally keep water but no other fluids from the meal tray. She confirmed that water pitchers are not provided in rooms to residents who are on fluid restrictions.Regarding the daily skilled assessments documenting Res. #3's gi status as within normal limits, the DON stated the assessment is a snapshot of the resident's condition at the time of the assessment. When asked to (continued on next page)

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