STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165350	A. Building B. Wing	11/25/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 - Actual harm Residents Affected - Few	Based on clinical record review, hospital record review, facility policy review, family and staff interviews, the facility failed to provide timely assessment and intervention for 2 of 3 (Resident #1 and Resident #8) residents in the sample. The facility failed to respond to reports of a change in condition for Resident #1, which resulted in a hospitalization for sepsis; and failed to notify the provider of the need to evaluate and review a 30-day order for psychotropic medications for a new admission (Resident #8) prior to their expiration. The facility reported a census of 85 residents. Findings include: 1. The Minimum Data Set (MDS) of Resident #1 dated 9/18/25 identified a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The MDS coded that the resident needed setup or clean-up assistance to eat. The MDS documented diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), heart failure, and diabetes.The Care Plan of Resident #1 identified a Focus Area of Needing Assistance with Activities of Daily Living (ADL). It documented Resident #1 as being independent with eating after staff set up. The Care Plan identified a Focus Area of Altered Cardiovascular Status. It directed staff to monitor/document and report as needed for any symptoms which included fatigue. The Care Plan identified a Focus Area of Risk of Increase in communication problems. It directed staff to allow adequate time to respond and request clarification from the resident to ensure understanding. It additionally directed staff to monitor/document for any physical/non verbal indicators of discomfort or distress and follow-up as needed and to monitor/document/report as needed any changes in ability to communicate. The Progress Note dated 10/26/25 at 4:47 pm documented Resident #1 was sent to the hospital due to altered Mental Status. The hospital records revealed an arrival time to the Emergency Department as 10/26/25 at 5:28 pm, being admitted to the Intensive Care Unit on 10/27/25 at 2:33 pm. The hospital records documented in the emergency room, the resident was hemodynamically stable (meaning her blood pressure, heart rate and circulation were steady and adequate) but she was not responding verbally. Per the note, she did follow simple instructions and the provider ordered a CT (computed tomography) scan (an imaging test to detect for injuries, internal bleeding, etc) which was unremarkable, with lab results indicating an underlying infection. Several hours later, a hospitalist physician documented that the resident had became increasingly hypoxic (not enough oxygen reaching the body's tissues or organs) and required up to 6 liters of oxygen. During the first day of hospitalization, the resident was given diagnoses which included Sepsis (a life-threatening condition that happens when a person's immune system response overreacts to an infection, which can damage body tissues and organs) with acute renal (kidney) failure; acute hypoxic respiratory failure (a life-threatening condition where the body's lungs fail to adequately provide oxygen to the bloodstream, leading to low oxygen levels) and acute metabolic encephalopathy (a rapid decline in brain function caused by a disturbance in the body's metabolism). She had not been released from the hospital at the time of the survey. On 10/30/25 at 12:28 pm, Staff A, Certified Medication Aide (CMA) stated that on Sunday, 10/26/25 she had last given Res #1 medication in the late afternoon. She stated she told the nurse at that time the resident was kind of staring off into space and not talking much. She was able to take her medication but appeared to have a hard time swallowing. She stated the resident normally could talk, although she was very soft spoken. On 10/30/25, Staff B, Certified Nurse Aide (CNA) stated that when she started her shift at 6:00 am on 10/26/25, she realized right away that Res #1 was not feeling well. She stated she went to the resident's room to get her up for breakfast, and Res #1 did not respond verbally and her breathing didn't seem normal. She stated she reported this to Staff C, Licensed Practical Nurse (LPN). She added that Staff C told her this had started on the prior day, 10/25/25. She said Staff C instructed her to get Res #1 up for breakfast so staff proceeded to get her up and took her to breakfast in the dining room. She described that Res #1 ate very little, and was having difficulty remaining sitting upright, as she was leaning forward in her wheelchair so she and another staff member put her back in bed. She stated they did not attempt to get the resident up for lunch. She was dressed and incontinence cares and positioning were provided throughout the rest of the shift. She stated they also pushed extra fluids as she was not eating and turned her more frequently than normal, approximately every hour. She stated she last saw her around 1:30 pm, and prior to that day, she had not worked with Res #1 for a few days. On 10/30/25 at 2:25 pm, the Advanced Registered Nurse Practitioner (ARNP) for the facility stated she had been told the resident had been sent out to the facility over the weekend due to stroke-like symptoms. She stated she was only aware of the facility calling the on call service on Sunday afternoon, October 26th, and otherwise no other calls had been recorded. She

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff interviews the facility failed to follow physician orders to remove a fentanyl patch prior to applying a new patch for 1 of 1 residents (Resident #2) reviewed. The facility reported a census of residents. Findings include: The Minimum Data Set (MDS) dated [DATE] revealed that Resident #3 had diagnoses of cancer, polyneuropathy due to other toxic agents, chronic obstructive pulmonary disease (COPD) and unspecified abdominal pain.The Care Plan initiated on 12/9/24 indicated that Resident #3 used Fentanyl related to pain and directed staff to administer the medication as ordered by the physician.The Physician's Order Summary Report dated 9/5/25 included an order for Fentanyl 25 mcg (micrograms) patch apply one patch topically to skin every 3 days and to remove old patch prior to the applying the new patch and to rotate sites.The Electronic Health Record (EHR) Progress Notes revealed that on 9/6/25 Resident #3 appeared to be confused and unable to answer questions. She was also looking around and was unable to voice needs. It also revealed that Staff A, Advanced Registered Nurse Practitioner (ARNP) was at the facility assessing the Resident #3 and noted that she was lethargic and confused with a history of urosepsis and hydronephrosis. Staff A, ARNP sent Resident #3 to the hospital given her current symptoms.The EHR revealed Resident #3's vital signs on 9/5/25 at approximately 11:30 AM were 98.4 temperature, 97 pulse, 107/69 blood pressure and 95% oxygen saturation.The Electronic Medication Administration Record (EMAR) dated 9/2025 indicated that Resident #3 had a 25 mcg (mcg) Fentanyl patch applied to the left arm on 9/2/25; and on 9/5/25 a patch placed on her right arm. The facility-controlled substance book confirmed a Fentanyl patch applied to Resident #3 on 9/2/25 was 25 mcg.The facility automated medication dispensing system report indicated that the Fentanyl patch removed and applied to Resident #3 on 9/5/25 was 25 mcg.The Emergency Medical Services (EMS) Patient Care Report dated 9/5/25 for Resident #3 indicated that a Fentanyl patch removed en route to the hospital. No further information regarding location, strength or date on patch included in report. The Emergency Department (ED) Physician Notes dated 9/5/25 indicated that Resident #3 had a second Fentanyl patched removed in the ED. No further information regarding the strength or location of the patch included in the report. The note listed diagnoses of sepsis, acute kidney injury, elevated liver enzymes, lactic acidosis, elevated thyroid stimulating hormone and anemia.The Physician Discharge summary dated [DATE], Hospital Course indicated, in part .On 9/7 Patient transferred to ICU (Intensive Care Unit) for fentanyl overdose with severe acute hepatic encephalopathy (a neuropsychiatric syndrome caused by diseased liver's inability to filter toxins, like ammonia, from the blood, allowing them to reach the brain) with increased ammonia levels in the 200's (normal 15 to 45; or 10.7 to 32 depending on type of test completed by the lab) .In an interview on 10/21/25 at approximately 8:50 AM Staff A, ARNP stated she was here on 9/5/25 prior to the transfer out of Resident #3 at around 11:30 AM. She was lethargic and confused. She believed she was septic as she has a history of urosepsis and she had a lower blood pressure and increased pulse. She did not look to see how many Fentanyl patches she had on but heard that she had two on.In an interview on 10/21/25 at 10:04 the consulting Pharmacist queried about how long a 72-hour Fentanyl patch would continue to put out medication, and he stated that 72 hours is based on averages so it could have been completely done or still releasing some medication. During an interview on 10/21/25 at 1:50 PM Staff C, Licensed Practical Nurse (LPN) queried about the 9/5/25 Fentanyl patch and she stated if she did place a patch from the automatic dispending system, she would need a second person as the machine required two sets of finger prints to remove a patch. She added she does not remember who signed with her that day. When told Resident #3 went to the hospital an hour after she applied the patch, she stated she did remember putting on the patch. She stated she remembered telling Staff A, ARNP that something was off about the resident. Staff C, LPN stated that she took off the old patch on the left arm as she has to before she can put on the new one. She also stated that she had a witness when she disposed of the previous patch and put it in the drug buster. She was unable to state where that would be documented. She does not remember who witnessed it but it would probably be the same one who helped her take the new one out. Then she added that if it was busy, it might have been someone else just so there was a witness.In interview on 10/22/25 at 8:08 AM Staff A, ARNP stated that Resident #3 had not been feeling well for a few days prior to her assessment on 9/5/25. She feels that Resident #3 had a urinary tract infection with sepsis based on her symptoms as she had presented that way the first time she met Resident #3. She does not feel that the resident was overdosed