DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165303	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION CENTERS OF INDEPENDENCE WEST CAMPUS	1610 THIRD STREET NE , INDEPENDENCE, Iowa, 50644

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 ✓ KBS	INITIAL COMMENTS Correction date: 9/30/25 The following deficiencies resulted from investigation of complaints #2577180-C, #1741249-C, and #2586299-I conducted August 11, 2025 to August 12, 2025. Complaint #1741249-C and #2577180-C resulted in a deficiency. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000		
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F0584		

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 reverse for further 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
[signature]	Administrator	9.12.2025

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F0584 SS = E	Continued from page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and resident interview, the facility failed to maintain a clean, comfortable and homelike environment. The facility reported a census of 56 residents. Findings include: 1. Observation on 8/11/2025 at 9:00 A.M. included: a. A Hall - Wall paper border above hand rail partially removed, peeling in multiple areas. Hall carpet with a large amount of dark stains and blackened colored areas. b. A Hall - Room #3, #5 - Room carpet with moderate amount of dark stains. c. C Hall - Room #26, #27, #36 - Room carpet with moderate amount of dark stains. 2. Observation on 8/11/25 at 8:15 A.M. revealed the following: The center hall carpet that went into the service hallway and the kitchen revealed darkened, blackish discoloration on the carpet with areas of solid blackened spots that measured the width of the doors. The carpet leading to the dining room from the center hallway was darkly discolored with blackened spots that measured the width of the double doors. Observations of the dining room at this time revealed multiple areas of darkened areas throughout the dining room, with areas	F0584		

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F0584 SS = E	Continued from page 2 of dark, black spots scattered throughout the dining room carpet. On 8/11/25 at 8:07 A.M. during an interview with Resident #7 while sitting in the dining room, the resident stated, "I don't like this dirty carpet in this dining room, it is worn out, dirty and needs cleaned". She stated, "I wish you could help me with this, it makes me sick to sit in here and eat my meals". On 8/12/25 at 8:20 A.M. during an interview with Staff A, Maintenance Supervisor, Staff A stated he also had concerns with the carpet and the condition of it. He stated in the summer it was hard to keep clean because of the humidity and this year all the rain had had. He reported due to recent rainfall event water came into the building which had made the carpet wrinkle. Staff A stated he last cleaned the carpet around Christmas of 2024 and stated it really needed it again. Staff A stated they had a resident who peeled the wall paper off the A Hall walls and they were working on how to fix this. The resident pulled off the wall paper almost immediately after he repaired it. Interview with Staff F, Housekeeping Supervisor on 8/12/25 at 11:00 A.M. revealed she had worked in the building since 2022, moved here from [Name Redacted] next door. The last time the carpets were cleaned was right before Mother's Day 2025, they spot clean the carpets regularly but it did not help. The carpet was very dirty and ground in dirt and spots. The carpet had been dirty since she transferred from the sister facility down the street.	F0584		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review and staff interviews, the facility failed to follow physician orders for one of three residents reviewed (Resident #2). The facility reported a census of 56 residents.	F0658		

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F0658 SS = D	Continued from page 3 Findings include: Resident #2's MDS (Minimum Data Set) dated 7/18/2025 revealed he had no cognitive impairment, had diagnoses including diabetes, absence left toes, anemia, heart failure, renal insufficiency, hypertension and had diabetic foot ulcers. The Care Plan identified the resident had a risk for alteration in skin integrity related to type two diabetes and other circulatory complications. It directed staff to administer treatments per physician orders, encourage good nutrition and hydration in order to promote healthier skin, and observe skin with ADL's (activities of daily living). A Wound Clinic Note dated 7/31/2025 included an order to provide one serving of Prostat AWC (advanced wound care), a protein supplement, one serving daily. Protein to assist with wound healing. On 8/12/2025 at 12:50 Staff B, DON (Director of Nursing) reported a staff nurse missed the wound clinic order for Prostat. It was hidden in the note dated 7/31/2025. On 8/12/2025 at 1:10 P.M., Staff G, LPN (Licensed Practical Nurse) reported she worked at the facility for 8 years. Resident #2 had a wound clinic order dated 7/31/2025. Staff G revealed she missed the Prostat order from the wound clinic, it was considered an order, and did not know how she missed it. Staff B put the order in the resident's record and notified the physician today. The facility policy titled Physician Orders/Transcription of Orders revised 7/2023 included the following: PURPOSE: To correctly and safely receive/transcribe physician's orders so correct order can be followed/administered. To ensure that patient medications, treatments, and plan of care are in accordance with the licensed providers orders.	F0658		
F0725 SS = D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable	F0725		

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F0725 SS = D	Continued from page 4 physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interviews, review of computerized call light response times, and facility policy review the facility failed to answer resident call lights in a timely manner for two of three residents reviewed (Resident #1, #6). The facility failed to have the call light within reach for one of seven residents reviewed (Resident #5). The facility reported a census of 56 residents. Findings include: 1.The MDS (Minimum Data Set) dated 7/2/2025 reported Resident #5 had severe cognitive impairment and had diagnoses including diabetes, history of falls and fracture of the left humerus. The MDS indicated the resident had a fall with no injury since the previous assessment. The resident's Care Plan directed staff to assist the resident with transfers and ambulation with the use of a gait belt, and ensure the call light is within reach. Observation on 8/11/2025 at 9:10 a.m. revealed Resident #5 seated in her room in a recliner with a bedside table at her right side. The call light sat on the bed against the wall. The resident stated she had to go to	F0725		

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F0725 SS = D	Continued from page 5 the bathroom and attempted to lower the footrest. The surveyor summoned staff and Staff E, Certified Nursing Assistant (CNA) entered the room, applied the gait belt, and assisted the resident to the bathroom. Staff E observed the call light on the bed and stated, "someone forgot to put the call light on her chair". 2. The MDS dated July 9, 2025 revealed Resident #6 had no cognitive impairment, and the Care Plan indicated the resident had a fall risk. During an interview on 8/11/2025 at 9:20 a.m., the resident revealed staff failed to answer his call light in a timely manner. Staff , at times took up to 30 minutes to respond when he put his call light on. The resident also reported staff would enter his room, turn the call light off and state they would be right back, but failed to do so. The facility Call Light Policy revised 9/2023 included the following purpose: To ensure that there is a prompt response to the resident's call for assistance. The facility also ensures that the call system is in proper working order. Procedures: 1. Facility shall answer call lights in a timely manner 2. Orient new residents as appropriate to the call light at bedside as well as the call light in the bathroom and in shower/tub rooms 3. Answer call lights in a prompt and courteous manner, knocking before entering and introducing self 4. When answering a call light, respond to the request. If immediate assistance cannot be provided and there is not an emergent need, call light may be turned off and resident informed that a staff member will be back to assist them shortly 5. If a call light is not functional, evaluate and provide another means in order for the resident to call for assistance (i.e. bell) until the call light is fixed. Notify the administrator/maintenance director immediately for repair 6. Call lights are to be placed within reach of residents for those residents who can use it. Frequent rounds and interventions per care plan must be followed for supervision of those patients who are physically and/or cognitively unable to utilize call light. (Soft touch call lights can be utilized if needed) 7. Be sure that when a call light is triggered, it will	F0725		

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F0725 SS = D	Continued from page 6 either alert the staff visually, audibly, or both. 3. Review of Resident #1's MDS dated 7/31/25 revealed the resident had intact cognitive ability. The resident had diagnoses which included surgical repair of right and left femur, Parkinson's and congestive heart failure. The resident reported the staff failed to answer her call light timely and reported incontinence episodes as a result. The resident stated she had kept records of the call lights but only recently started the log. During an interview on 8/12/25 at 10:10 am, the resident revealed that last evening at 6:00 pm she put on her call light and the staff failed to answer her call light until 6:50 pm. Interview and review of the computerized Call Light Wait time logs on 8/12/25 at 10:30 am with Staff C-Quality Assurance/Certified Medication Aide revealed the following extended call light response times for Resident #1: a. On 8/5/25 the resident activated her call light at 10:16 am, the staff failed to answer the call light for 28 minutes and 48 seconds. b. On 8/6/25 the resident activated her call light at 8:44 am, the staff failed to answer the call light for 31 minutes and 34 seconds. At 6:21 pm the resident activated her call light, the staff failed to answer the call light for 20 minutes and 24 seconds. c. On 8/7/25 the resident activated her call light at 5:09 am, the staff failed to answer the call light for 25 minutes and 25 seconds. At 12:04 pm the resident activated her call light, the staff failed to answer the call light for 40 minutes and 10 seconds. d. On 8/9/25 the resident activated her call light at 6:36 am, the staff failed to answer the call light for 33 minutes and 6 seconds. At 1:00 pm the resident activated her call light, the staff failed to answer the call light for 19 minutes and 6 seconds. e. On 8/10/25 at 6:16 am the resident activated her call light, the staff failed to answer her call light for 19 minutes and 9 seconds. At 6:18 pm the resident activated her call light, the staff failed to answer her call light for 23 minutes and 45 seconds. e. On 8/11/25 at 8:03 am the resident activated her call light, the staff failed to answer the call light	F0725		

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F0725 SS = D	Continued from page 7 for 22 minutes and 9 seconds. At 12:36 pm the resident activated her call light, the staff failed to answer her call light for 22 minutes and 4 seconds. At 1:55 pm the resident activated the call light, the staff failed to answer her call light for 17 minutes and 2 seconds. At 6:10 pm the resident activated her call light, the staff failed to answer her light for 42 minutes and 14 seconds.	F0725		

Rehabilitation Centers of Independence West Campus
1610 3rd Street NE, Independence, Iowa, 50644

Plan of Correction (POC) related to survey completed: 8/12/2025
Date POC submitted to DIAL: 9/12/2025

F000 Correction Date: 9/30/25

For the required Plan of Correction, the facility submits the following:

.**F584 Safe/Clean/Comfortable/Homelike** Environment Correction Date: 9/30/2025

1. Residents continue to reside safely in the facility. Carpet cleaning was completed on 9/2 and 9/3/25. Wallpaper boarder replacement was ordered on 8/21/2025, installation to occur upon receipt by the Maintence Director. Residents interviewed who expressed concerns were reassured of corrective actions and educated on the cleaning schedule.

2. Housekeeping staff received education on 9/9/25 regarding the use of correct chemicals per Nassco and extractor instructions. A biweekly carpet cleaning schedule has been implemented with daily spot treatments and full monthly dining room cleaning. Outside carpet cleaning vendors have been contacted for supplemental services. A checklist for extractor use is being created to ensure consistent process, and equipment training is planned through the maintenance provider.

3. The Administrator or designee will complete weekly audits of carpet condition and cleaning schedules for three months. Audit results will be reviewed through the facility QA process for three months to ensure continued compliance and to determine if further monitoring is needed.

F658 Services Provided Meet Professional Standards Correction Date: 9/30/2025

1. The wound clinic order for Resident #2 was immediately entered into the medical record, and the physician was notified. The resident began receiving the prescribed supplement on 8/13/2025.

2. Education was provided to nursing staff on 8/13/2025 regarding order entry and transcription procedures. Administrative nursing staff now complete daily double checks of new orders, and Medical Records personnel will not upload new orders unless two nurses have signed off on review. Any discrepancies are routed to administrative nursing for resolution.

3. Administrative nursing staff will conduct daily audits of new orders for three months. Audit results will be reviewed through the facility QA process for three months to ensure compliance and determine whether ongoing auditing is required.

F725 Sufficient Nursing Staff Correction Date: 9/30/2025

1. Residents identified without potential timely call light response or call light within reach were immediately assisted, and their needs were reassessed.

2. The call light system was reviewed, and additional log-ins were added for agency Certified Nursing

Assistants. Education was provided on 09/08/2025 to agency and facility staff on proper use of the call light system, log-in procedures, and response expectations. Administrative nursing staff will rotate monitoring by carrying call light pagers during shifts. Education was also provided to floor staff regarding prompt call light response and use of call light pagers.

3. Facility Quality Assurance coordinator or designee will conduct call light response audits five days per week for three months. Results will be reviewed through the facility QA process for three months, and ongoing monitoring needs will be determined based on outcomes.