

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145616	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Mason City Area Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 520 North Price Avenue Mason City, IL 62664	

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)
<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31285</p> <p>Based on interview, record review and observation, the facility failed to ensure residents were free from unnecessary physical restraints(s), failed to identify the specific medical symptoms warranting the use of physical restraints, failed to obtain physician orders with medical justification for the placement of a physical restraint(s), and failed to obtain resident or responsible party consent for the use of a physical restraint for two (R1, R2) of 12 residents reviewed for restraint usage in the sample of 12. These failures resulted in R1 and R2 being physically restrained to their wheelchair with a gait belt placed around their torso and fastened behind their back with the inability to rise from their chair and suffering psychosocial harm of humiliation and embarrassment that any reasonable person would experience being improperly restrained.</p> <p>These failures resulted in an immediate Jeopardy.</p> <p>An Immediate Jeopardy situation was identified to have started on 01/01/25 at approximately 6:00pm when V3 LPN/Licensed Practical Nurse placed a gait belt around R1 and R2's torso and fastened the restraint behind the back of each resident's wheelchair, preventing R1 and R2 the ability to rise from their wheelchair or remove the restraint.</p> <p>While the immediacy was removed on 02/20/25, the facility remained out of compliance at a Severity Level 2 as additional time is needed to evaluate the implementation and effectiveness of the facility's removal plan and quality assurance monitoring.</p> <p>Findings include:</p> <p>The facility's final Report to Illinois Department of Public Health, dated 01/10/25 identified R1 and R2 as the subjects of the incident. This report documents the following: On 01/06/25 CNA (verified as V4) reported that (R2) was improperly restrained on evening shift but was unsure when it happened. This report further documented, Interviews with staff revealed that on the evening of 01/01/25, Resident (R2), BIMS/Brief Interview for Mental Status 0 (zero/severely cognitively impaired), was improperly restrained in her wheelchair. The report stated, Staff interviews reveal they observed the resident at the nurse's station improperly restrained. Staff said they observed a second resident, (R1), BIMS 01 (severely cognitively impaired), improperly restrained to his wheelchair at the nurse's station. Neither resident was able to provide any comment upon interview.</p> <p>(continued on next page)</p>

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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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's Restraint Program Policy and Procedure, dated 11/10/2015, documents the following: Policy: It is the policy of this facility to provide appropriate care for residents in relation to restraint utilization. 3. If a restraint is necessary, physician and POA (Power of Attorney) are notified, and a Restraint Consent is completed. Specific risk factors are marked as appropriate for the individual resident.</p> <p>The facility's Nonemergency Use of Physical Restraints policy dated 3/1/11 documents the following:</p> <p>I. Physical restraints shall be used when required to treat the resident's medical symptom or as a therapeutic intervention, as ordered by a physician, and based on: A. the assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives that could prove effective; B. the assessment of a specific condition or medical treatment that requires the use of a physical restraints, and how the use of physical restraints will assist the resident in reaching his or her highest practicable, mental, physical, mental, or psychosocial wellbeing.</p> <p>II. A physical restraint will be used only with the informed consent of the resident, the resident's guardian, or other authorized representative This informed consent will include information about potential negative outcomes of physical restraint use, including incontinence, decreased range of motion, decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact.</p> <p>VII. Physical restraints will not be used on a resident for the purpose of discipline or convenience.</p> <p>The facility's Emergency Use of Physical Restraints policy dated 7/1/02 documents: B. If a resident needs emergency care and other less restrictive interventions have proved ineffective, a physical restraint will be used briefly to permit treatment to proceed. The attending physician will be contacted immediately for orders. If the attending physician is not available, the facility's advisory physician or Medical Director will be contacted. 11. The emergency use of a physical restraint will be documented in the resident's record and include: 1. The behavior incident that prompted the use of the physical restraint; 2. The date and times the physical restraint was applied and released; 3. The name and title of the person responsible for the application and supervision of the physical restraint; 4. The action by the resident's physician upon notification of the physical restraint use; 5. The new or revised orders issued by the physician; 6. The effectiveness of the physical restrain in treating medical symptoms or as a therapeutic intervention and any negative impact on the resident; and 7. The date of the scheduled care planning conference or the reason the resident's emergency need for physical restraints. III. The facility's emergency use of the physical restraints will comply with our policy for non-emergency use of physical restraints section III, IV, V, and IX.</p> <p>The facility's Abuse Prohibition policy dated 3/15/18 documents the following: All residents have the right to be free from verbal, sexual, physical, mental abuse, neglect, misappropriation of property, exploitation. This includes but is not limited to freedom from .physical or chemical restraints not required to treat the resident's symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1's medical record documents R1 is [AGE] years old and was admitted to the facility on [DATE] with diagnoses including: Unspecified Dementia with Agitation; Alzheimer's Dementia; Impulsiveness and Generalized Muscle. Weakness.</p> <p>R1's current Care Plan documents R1 has significant cognitive impairment, is dependent on staff for ADLs/Activities of Daily Living, transferring and ambulation. R1's MDS/Minimum Data Set, dated dated [DATE], documents R1's BIMS/Brief Interview for Mental Status score was 01 of 15, indicating R1 is severely cognitively impaired; R1 uses a wheelchair, requires assistance with ambulation and ADLs.</p> <p>R2's medical record documents R2 is [AGE] years old and was admitted to the facility on [DATE] with diagnoses including: Dementia with other Behavioral Disturbance; Disorientation; Cognitive Communication Deficit; Weakness; Recurring Falls; Anxiety Disorder and Insomnia.</p> <p>R2's current Care Plan documents R2 is dependent upon staff for cares, including transferring, ambulation, and ADL's/Activities of Daily Living. R2's Care Plan documents R2 has significant cognitive impairment and is a fall risk. R2's Quarterly MDS Cognition Assessment documents R2 has severe cognitive impairment with a BIMS score of 0 (zero) of 15.</p> <p>There was no documentation, no physicians order, and no medical symptom listed justifying the use of this inappropriate restraint in R1's nor R2's medical records.</p> <p>The facility's January 2025 Nursing schedule documents V3 LPN/Licensed Practical Nurse worked the evening shift on 01/01/25 and 01/03/25.</p> <p>On 02/11/25 at 2:10pm, V6 CNA stated that on 01/06/25 she and another CNA were getting R2 ready to get out of bed, when she noted a gait belt fastened around R2's wheelchair. When V6 mentioned the gait belt, the other CNA told her that on 01/01/25, V3 LPN/Licensed Practical Nurse had used gait belts to keep (R2) in her wheelchair. V6 stated R2 was continent of bowel and bladder and able to let the staff know if she needed to use the bathroom and was able to ambulate with CNA assistance to the bathroom in her room, and a fall risk due to weakness.</p> <p>On 2/11/25 at 2:45pm V3 LPN/Licensed Practical Nurse stated that on 01/01/25 at approximately 6:00pm, she fastened a gait belt around R1 and R2 while they were sitting in their wheelchairs near the Nurses Station. V3 stated she fastened the gait belts behind the back of the chairs, out of the residents' reach, in order to prevent R1 and R2 from rising from their wheelchairs. V3 confirmed she was aware her actions constituted inappropriate use of physical restraints at the time. V3 stated R2 uses a cushioned lap restraint and removes it frequently and tries to stand up from her wheelchair. V3 stated it was a very busy and hectic time, after dinner, and no staff were available to keep watch on R1 and R2, as CNAs were transferring and toileting the residents and putting some residents to bed for the evening. V3 stated she felt R1 and R2 required 1:1 attention to prevent a fall when trying to stand up from their wheelchairs and there was not enough staff on duty to provide it.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 02/11/25 at 9:00am V6 CNA stated she was on duty on 01/01/25 on 2nd shift and, at approximately 6:00pm, V3 LPN was working and R1 was anxious and repeatedly asking for his wife at the Nurses Desk. V6 stated she saw V3 place a gait belt across (R1's) chest, under his arms and fastened it in the back of his wheelchair. V6 stated R1 has dementia and severe hearing deficit and does not always process what you're saying and does not follow commands. V6 stated R1 is ambulatory with assistance and is very unsteady. V6 stated she did not report the incident to the Abuse Coordinator/Administrator because she felt V3 LPN was not approachable as she seems rude.</p> <p>On 02/11/25 at 2:00pm V4 CNA/Certified Nursing Assistant stated that on 01/06/25, a CNA (unable to identify) she was working with told V4 that V3, LPN restrained R2 in her wheelchair with a gait belt to keep her in her wheelchair. V4 stated she immediately reported the incident to a supervising nurse and V1 Administrator/Abuse Coordinator.</p> <p>On 02/11/25 at 1:30pm V7 LPN stated she was on duty with V3 LPN on the evening shift of 1/1/25. V7 stated at approximately 6:00pm, she saw R1 was restrained in his wheelchair with a gait belt. V7 stated she was aware V3 had placed a gait belt around R1 and fastened it behind the back of his wheelchair. V7 stated R1 would not have been able to remove the gait belt and would not have been able to rise from the wheelchair. V7 verified she did not report the incident to anyone. V7 stated she knew this was improper restraining of a resident at the time of the incident and, even though she knew that the policy was to report incidents immediately to the Administrator/Abuse Coordinator, she did not report it.</p> <p>On 2/11/25 at 10:45am V2 DON/Director of Nursing stated V3 LPN inappropriately restrained R1 and R2 in their wheelchairs using gait belts fastened around them and clasped behind the back of their wheelchairs, out of reach of the residents. V2 confirmed V3 should not have restrained R1 and R2 in that manner and the action constituted inappropriate use of restraints.</p> <p>On 2/11/25 at 11:15am V2 DON stated there were interventions in place for R1 and R2, including redirection, implementing an activity with an Activity staff member with one on one assistance; television viewing and taking R1 and R2 for a walk around the facility with CNA assistance.</p> <p>On 2/13/15 at approximately 10:00am, V2 stated the fall preventions interventions in place for R2 were providing a low bed, and a mattress next to her bed when she is sleeping; a pressure bed alarm, a cushioned lap restraint when R2 is up in her wheelchair. Redirection interventions included taking a walk with CNA assistance, distraction with activities and television viewing.</p> <p>On 2/11/25 at 1:15pm, V1 Administrator stated she was notified of this incident on 01/06/25, after the incident occurred on 01/01/25, and began the investigation of the incident immediately, calling the evening shift staff for questioning. V1 stated she first called V3 LPN/Licensed Practical Nurse for information, who had worked the evening shift on 01/01/25 and was usually considered the charge nurse for the shift. V1 stated V3 readily admitted that she had placed gait belts around R1 and R2 in their wheelchairs and fastened them out of their reach, behind the backs of the wheelchairs in order to prevent them from standing. V1 verified V3 stated she was aware the incident constituted inappropriate physical restraints when she did it. V1 stated she suspended V3 immediately, pending the outcome of the facility's investigation.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 2/18/25 at 3:55pm, V1 stated she did not bring this incident to the attention of the IDT/Interdisciplinary Team or QA/Quality Assurance members. V1 stated the next QA meeting will be in April 2025.</p> <p>On 2/11/25 at 9:20am R1 was seated in his wheelchair at a table near the Nurses Station, working with building block materials with an activities aid. R1 was calm with no behaviors exhibited. No restraints were noted. R1 did not respond to this surveyor's greeting or question.</p> <p>On 2/11/25 at 11:20am, R1 was calm and quiet, self-propelling his wheelchair down the hallway toward his room. R1 did not respond to surveyor's greeting or question. No restraints noted.</p> <p>On 2/11/25 at 3:00pm R1 was in bed with his eyes closed. There were no restraints noted.</p> <p>On 2/13/25 at 9:45am, R1 was sitting in a wheelchair near the Nurses Station. R1 was alert, calm and quiet. R1 did not respond to this surveyor's greeting or question.</p> <p>On 2/11/25 at 9:20am R2 was sitting in a high-backed wheelchair with a lap cushion in place.</p> <p>On 2/11/25 at 10:05am, R2 was seated in a high-backed wheelchair near the Nurses Station. A lap cushion was in place, and R2 was counting out loud with her eyes closed. R2 did not respond to this surveyor's greetings or questions.</p> <p>On 2/11/25 at 3:05pm, R2 was lying in bed with her eyes closed. The pressure alarm on R2's bed was turned on.</p> <p>An Immediate Jeopardy situation was identified to have started on 01/01/25 at approximately 6:00pm when V3 LPN/Licensed Practical Nurse placed a gait belt around R1 and R2's torso and fastened the restraint behind the back of each resident's wheelchair, preventing R1 and R2 the ability to rise from their wheelchair or remove the restraint.</p> <p>V1 (Administrator) and V2 (Director of Nursing) were notified of the Immediate Jeopardy on 02/20/25 at 9:47 AM.</p> <p>On 2/25/25, the abatement plan was confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> On 2/20/25 Department Managers (V2 DON; V13/Acting DON; V15/MDS/Care Plan Coordinator; V11/RN Restorative Nurse; V19/Business Office; V20/Social Services; V21/Activity Director; V22/CDM; V23/Environmental Services Director) were in-serviced by V1 Administrator on the facility's restraint policy, care of residents with restlessness and agitation, improper restraint usage, the need for alternative interventions, appropriate diagnosis, physician's orders, care planning, the facility's abuse policy and reporting procedure. The facility's Department Managers then carried out the same in-services for their respective employees. All employees of the facility have been in-serviced on these topics and policies. On 2/20/25 all residents have been assessed to ensure that none are restrained improperly or unnecessarily. <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>3. On 2/20/25 Care Plans were reviewed by the Care Plan Coordinator and updated as needed for residents with restlessness or agitation.</p> <p>3. On 2/20/25 a full physical assessments of R1 and R2 were conducted by for any signs of injury from restraint usage with no findings of injury.</p> <p>5. All facility staff, contracted Therapy staff and Agency staff utilized by the facility were in-serviced on the following: care of the resident with restlessness and/or agitation; the facility's restraint policy, improper restraint usage, the need for alternative interventions, care of the resident with restlessness and/or agitation, appropriate diagnosis, physician's orders, care planning, the facility's abuse policy and reporting procedure on 02/20/25.</p> <p>6. V15 verified R2 was care planned with interventions addressing potential for abuse and proper restraints related to her diagnoses. Restraint consents were present in R2's medical record for R2's cushioned lap restraint, mattress, and bed pressure alarm.</p> <p>V15 verified R1 was care planned for falls and restlessness, agitation with interventions. No restraints were in use for R1.</p> <p>7. A system was put in place for an audit to be done by the V1 Administrator or designee three times weekly to ensure compliance with the interventions put in place. V2 DON conducted daily reviews of the 24-hour Report for any new or additional restraint usage. These are monitored/audited for compliance by V1 three times per week.</p> <p>The results of the audits will be discussed at the next Quality Assurance meeting in April 2025.</p> <p>8. On 02/20/25 all residents were interviewed regarding history or existence of unnecessary restraint usage and abuse incidents. No incidents were reported by the residents. These interviews were conducted and documented by the V2 DON, V 1 Administrator, V15 MDS/Care Plan Coordinator, V13 ADON/Assistant Director of Nursing and Department Managers.</p> <p>9. On 02/20/25 V15 Care Plan Coordinator reviewed and updated Care Plans for those residents with restraints, agitation, restlessness or exhibition of behaviors. R2 was the only resident identified with restraint utilization.</p> <p>10. ON 2/20/25 Agency staff were in-serviced and Resident Rights, improper restraint usage and the Abuse/Neglect policy to the Agency Orientation Binder.</p> <p>11. The Interdisciplinary Team met on 2/20/25 and reviewed, discussed and approved the facility's Immediate Jeopardy Removal Plan.</p> <p>10. V15 Care Plan Coordinator completed Care Plan audits for all residents and a system was put in place to audit five residents' Care Plans per week.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>31285</p> <p>Based on interview and record review the facility failed to immediately report inappropriate use of a physical restraint to the facility's Abuse Coordinator for two of 12 residents (R1, R2) reviewed for restraint usage in the sample of 12.</p> <p>Findings include:</p> <p>The facility's Abuse Prohibition policy, dated 03/15/2018, documents the following: Reporting - Allegations Of Abuse And Neglect: 1. A facility employee or agent or covered individual who becomes aware of alleged abuse or neglect of a resident shall immediately report the matter to the facility administrator. The Abuse Prohibition policy continues, documenting: Abuse and Neglect Prohibition: 1. All resident have the right to be free from verbal, sexual, physical, mental abuse, corporal punishment, involuntary seclusion, neglect, misappropriation of property, exploitation. This includes seclusion and physical or chemical restraints not required to treat the resident's symptoms.</p> <p>On 2/11/25 at 2:45pm V3 LPN/Licensed Practical Nurse stated that on 01/01/25 at approximately 6:00pm, she fastened a gait belt around R1 and R2 while they were sitting in their wheelchairs and fastened the gait belt behind the back of the chair, out of the residents' reach, in order to keep R1 and R2 in their wheelchairs. V3 confirmed she was aware her actions constituted inappropriate physical restraints.</p> <p>On 02/11/25 at 1:30pm V7 LPN stated she was on duty with V3 LPN on 1/1/25. V7 stated she saw that V3 had placed a gait belt around R1 and fastened it behind the back of his wheelchair. V7 stated she knew this was wrong but did not report the incident to a supervisor or the Administrator/Abuse Coordinator.</p> <p>On 2/11/25 at 9:20am V6 CNA/Certified Nursing Assistant stated, I saw V3 place a gait belt across (R1's) chest, under his arms and fastened it in the back of his wheelchair. R1 would have been unable to release the gait belt. V6 stated she did not report the incident to a supervisor or the Abuse Coordinator/Administrator.</p> <p>On 2/11/25 at 1:30pm, V4 CNA stated that on 01/06/25 another CAN (unable to identify) told her that V3 had restrained R2 in her wheelchair with a gait belt. V4 stated she immediately reported this to a supervising nurse and the Administrator who is the facility's Abuse Coordinator.</p> <p>On 2/11/25 at 2:30pm, V2 DON verified the physical restraining of R1 and R2 by V3 LPN should have been immediately reported to the Abuse Coordinator/Administrator and was not reported to her until 01/06/25.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>31285</p> <p>Based on record review and interview the facility failed to ensure a Registered Nurse (RN) worked at least eight hours daily. This failure has the potential to affect all 56 residents residing within the facility.</p> <p>Findings include:</p> <p>The facility's Staffing policy dated 01/16/2018 documents: There shall be at least one registered nurse on duty seven days per week, 8 consecutive hours in a skilled nursing facility.</p> <p>The facilities Resident Roster dated 2/11/25, provided by V2 Director of Nursing documents 56 residents currently reside within the facility.</p> <p>The facility's Nurse Schedules for January 1 through January 31, 2025, document the facility did not have the services of an RN at least eight hours a day on 01/01/25, 01/04/25, 01/05/25, 01/18/25 and 01/19/25.</p> <p>On 02/0/25 at 11:18am V2 Director of Nursing verified the nursing schedules were accurate and the facility did not have an RN working in the facility for at least eight hours on 01/01/25, 01/04/25, 01/05/25, 01/18/25 and 01/19/25.</p>