

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 12/04/2024
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 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>35509</p> <p>Based on interview and record review, the facility failed to have a Registered Nurse for eight consecutive hours in a 24-hour period on four of 30 days per the Facility's November Nursing Schedule, and on four of 31 days per the Facility's October Nursing Schedule. This has the potential to affect all 52 residents living in the facility.</p> <p>Findings:</p> <p>The document, Nursing, dated 1/16/18, states, There shall be at least one registered nurse on duty seven days per week eight consecutive hours, in a skilled nursing facility.</p> <p>The Facility's October Nursing Schedule shows that on four weekend days, 10/12/24, 10/13/24 and 10/26/24, 10/27/24, there was not eight hours coverage by a Registered Nurse in a 24-hour period.</p> <p>The Facility's November Nursing Schedule shows that on four weekend days, 11/9/24, 11/10/24 and 11/23/24, 11/24/24, there was not eight hours coverage by a Registered Nurse in a 24-hour period.</p> <p>On 12/02/24 at 11:00 AM, V1, Administrator, stated, I know that we have not had a registered nurse on several weekends in the past months. I have been trying to hire a Registered Nurse for the weekend schedule, but it's been difficult.</p> <p>The facility's Long-Term Care Facility Application for Medicare and Medicaid Form CMS (Centers for Medicare and Medicaid Services) 671 dated 12/01/24, signed by V1, Administrator, documents 52 residents currently reside within the facility.</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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38396</p> <p>Based on observation, interview and record review, the facility failed to document a diagnosis, identify behaviors, and monitor for identified targeted behaviors to warrant the use of psychotropic medications and attempt a gradual dose reduction of an antipsychotic medication for five of five residents (R5, R6, R34, R36, R39) reviewed for psychotropic medications in the sample of 33.</p> <p>Findings include:</p> <p>1. On 12/03/24 at 9:17 AM, R6 was sitting in her room in a wheelchair. R6 stated she is happy with her care in the facility and was pleasantly confused with conversation. R6 was not exhibiting any behaviors.</p> <p>R6's current Physician Order sheet, dated 12/4/24 documents R6 has an order for Seroquel 25 milligrams (antipsychotic), Give 0.5 tablet (12.5 milligrams) by mouth in the evening related to Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety.</p> <p>R6's current Care Plan, dated 4/17/23, documents R6 is [AGE] years old and has diagnoses including but not limited to Anxiety, Alzheimer's Disease, Disorientation, Dementia without Behavioral Disturbance and Major Depressive Disorder. R6's care plan also documents I (R6) use antipsychotic/hypnotic medications related to Dementia without behavioral disturbances, psychotic disturbance, mood disturbance, and anxiety.</p> <p>R6's Psychoactive Medication Quarterly Evaluation, dated 10/18/24, documents R6 is taking the antipsychotic medication Seroquel for a medical diagnosis/indication of Dementia without behavioral disturbance.</p> <p>R6's Behavior Monitoring and Intervention report, dated 6/1/24-12/3/24, documents R6 has had two days with behaviors of frustration/anger, screaming at others, agitated, sad/tearful and screaming not at others. Both occasions occurred in August of 2024.</p> <p>On 12/3/24 at 2:15 PM, V1 (Administrator) confirmed the provided behavior monitoring report shows (R6's) documented behaviors in last six months. V1 stated (R6's) family declines her GDR's all of the time. They never want her medications reduced.</p> <p>R6's Social Service Note, dated 4/22/2024 at 11:07 AM, documents (Depression Score assessment) conducted with (R6) on 4/19/2024. (R6) noted to have no concerns or issues with her mood. (R6) has diagnosis of Dementia and is receiving Seroquel per Physician orders, diagnosis of Alzheimer's. (R6) has had no behaviors in her 14 day look back period.</p> <p>R6's Pharmacy recommendation, dated 5/3/24, documents a recommendation to decrease R6's Seroquel to 12.5 milligrams six evenings a week and omit Sunday. This GDR was denied by V14 (R6's Physician) for the reason: Family noticed worsening mood symptoms after previous reduction in the medication.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R6's Pharmacy recommendation, dated 11/1/24, documents a recommendation to decrease R6's Seroquel to 12.5 milligrams six evenings a week and omit Sunday. This GDR was denied by V14 (R6's Physician) for the reason: Has a lot of anxiety symptoms and family refuses decrease usually.</p> <p>On 12/4/24 at 10:00 AM, V8 (Certified Nursing Assistant, CNA) and V9 (CNA) both stated R6 has behaviors of crying & being emotional. V8 stated Sometimes it's bad dreams and (R6) knows it's not true and was a dream but she says they stick with her and upset her. (R6) isn't a harm to herself or other residents. (R6's) behaviors are not psychotic or uncontrolled in nature.</p> <p>On 12/4/24 at 10:09 AM, V7 (Licensed Practical Nurse) stated (R6's) behaviors are anxiousness, crying and frustration. (R6) isn't a threat or harmful to other residents or herself.</p> <p>On 12/4/24 at 12:30 PM, V10 (Registered Nurse/ Minimum Data Set coordinator) stated (R6's) behaviors are sadness, anxiousness, and tearfulness. (R6) admitted in 4/2023 with Seroquel and her family said she had been on it forever. (R6's) behaviors are not present when family is here, they are in the morning or after her family leaves. At this time V10 confirmed, R6 does not display behaviors that are psychotic in nature, does not have a diagnosis to support her antipsychotic medication, is not at risk for harming herself or other residents and has not had a GDR (gradual dose reduction) of her Seroquel in the last year.</p> <p>2. On 12/2/24 at 11:10 AM, R36 was observed being wheeled out of his room and taken to the dining room. R36 interacted with staff while in the common areas and the dining room and was not displaying any behaviors.</p> <p>R36's Physician Order Sheet, dated 12/4/24 documents R36 has an order for Seroquel 25 milligrams (antipsychotic), Give one tablet by mouth at bedtime related to unspecified Dementia, moderate, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety.</p> <p>R36's current Care Plan, dated 3/18/24, documents R36 is [AGE] years old and has diagnoses including but not limited to Dementia without Behavioral Disturbance and Major Depressive Disorder. R36's care plan also documents I (R36) use antipsychotic/hypnotic medications related to Dementia without behaviors. (R36) has the diagnoses of Dementia, Parkinson's and Depression and is receiving medications per Physicians orders. (R36) also has history of Traumatic Brain Injury and Seizures. (R36) gets very obsessive over his medications and wants them at certain times. (R36) has Meniere's Disease which can cause communication issues. (R36) is noted to be agitated with staff at times.</p> <p>R36's Behavior Monitoring and Intervention report, dated 6/1/24-12/3/24, documents R36 has had one day with a behavior of Public Sexual Acts which occurred on 10/3/24 and was improved with redirection from staff. No other behaviors are documented on this monitoring report for the previous six months.</p> <p>On 12/4/24 at 10:00 AM, V8 (CNA) and V9 (CNA) both stated R36 does not have any behaviors. V8 stated (R36) does pretty good. He used to try to get up a lot on his own but not really anymore. (R36) is not harmful to other residents or himself and doesn't have any behaviors of psychosis.</p> <p>On 12/4/24 at 10:09 AM, V7 (Licensed Practical Nurse) stated R36 does not have any behaviors and is not a threat to himself or other residents.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/4/24 at 12:30 PM, V10 (Registered Nurse/ Minimum Data Set coordinator) stated (R36) has behaviors of inappropriate comments towards staff and refusals of care. He's very particular about the timing of his medications for Parkinson's disease. V10 confirmed R36 is not at risk to harm other residents or himself and does not have behaviors or a diagnosis that is Psychotic in nature to warrant the use of his Seroquel.</p> <p>31283</p> <p>3. R34's current Physician's Orders document the following medication orders: Seroquel (antipsychotic) 25 milligrams by mouth every Monday, Tuesday, Wednesday, Thursday, Friday and Saturday for Dementia with Behavioral Disturbance; Venlafaxine (antidepressant) 150 milligrams by mouth in the morning related to Depression; Xanax (benzodiazepine/anti-anxiety) 0.25 milligrams by mouth every 8 hours as needed for Anxiety (date of order 11/11/24); and Xanax 0.25 milligrams by mouth twice daily for Anxiety Disorder.</p> <p>R34's current care plan documents the following focuses: (R34) has diagnosis for Depression and has a potential for a decline in her mood. Mood interview conducted as needed; I (R34) use anti-anxiety medications related to Anxiety Disorder; I (R34) use antidepressant medication related to Depression. (R34) prefers to stay in room and not participate with Activities or go to Main Dining Room for meals; and (R34) noted to be very tearful and anxious. (R34) noted to have visual hallucinations with delusional comments at times. (R34) also noted to be accusing, cursing, express frustration, and screaming at others. Noted to being agitated, panic, and screaming not at others.</p> <p>R34's current medical record does not contain documentation of behavior monitoring specific to the above-mentioned identified target behaviors.</p> <p>On 12/02/24 at 10:45 AM, R34 was sitting in her wheelchair near the fish tank in the front lobby visiting with her husband. R34 was dressed, groomed, and wearing glasses. R34 was alert and answering questions appropriately. R34 stated things are going well at the facility and denied having issues or concerns. R34 then stated, I would like to do more therapy. I did it a while back and I have been taken off. R34 was cooperative did not display any adverse behaviors at this time.</p> <p>On 12/04/24 at 11:20 AM, V10 (Registered Nurse/Care Plan/Minimum Data Set Coordinator) stated she is the individual at the facility responsible for overseeing psychotropic medication use. V10 stated R34 is not a harm to herself or others. V10 stated she could not provide documentation of behavior monitoring for R34's identified target behaviors. V10 confirmed R34 has the following PRN (as needed) order in place since 11/11/24: Xanax 0.25mg by mouth every 8 hours as needed for Anxiety. V10 stated R34's PRN Xanax is in place for, family preference.</p> <p>4. R5's current Physician's Orders document the following medication orders: Seroquel (antipsychotic) 50 milligrams by mouth at bedtime Monday, Tuesday, Thursday, Friday, Saturday related to visual hallucinations; and Bupropion (antidepressant) 100 milligrams by mouth daily related to Depression.</p> <p>On 12/02/24 at 10:30 AM, R5 was propelling in a high-back chair near the nurses' station. R5 was dressed, groomed, and appeared pleasantly confused. R5 could answer basic questions, stated things are going well, and denied having any current issues or concerns. No adverse behaviors were displayed by R5 at this time.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R5's current care plan documents the following focus: (R5) is currently receiving medications per physician orders for diagnoses of Vascular Dementia, Anxiety, Depression, and Visual Hallucinations. Visual Hallucinations noted with delusional comments. For diagnoses for Alzheimer's, she has no medicinal interventions in place at this time. There are times that (R5) will yell and scream and be combative with staff due to her Dementia. With her Depression diagnosis, she has the potential for a decline in her mood. (R5) noted to instigate a joking manner amongst staff, other residents, visitors.</p> <p>R5's current medical record does not contain documentation of behavior monitoring specific to the above-mentioned identified target behaviors.</p> <p>On 12/04/24 at 11:30 AM, V10 (Registered Nurse/Care Plan/Minimum Data Set Coordinator) stated R5 is not a harm to herself or others. V10 stated she could not provide documentation of behavior monitoring for R5's identified target behaviors.</p> <p>50627</p> <p>5. R39's current Physician's Orders document the following medication orders: Seroquel (antipsychotic medication) 75 milligrams by mouth at bedtime for visual hallucinations.</p> <p>R39's current care plan documents the following focus: (R39) has antipsychotic/hypnotic medications r/t (related to) Depression e.g. (example) visual hallucinations. R39 follows up with Psychiatry.</p> <p>R39's current medical record does not contain documentation of behavior monitoring specific to the above-mentioned identified target behaviors.</p> <p>On 12/01/24 at 10:30 AM, R39 was lying in bed waiting for staff to assist her with changing her adult brief. R39 was alert, oriented, and answering questions appropriately. R39 did not display any adverse behaviors at this time.</p> <p>R39's Minimum Data Set Assessment (dated 09/06/24) documents a BIMS (Brief Interview for Mental Status) score of 14, indicating R39 is cognitively intact.</p> <p>On 12/04/2024 at 1:30 PM, R39 stated that she takes Seroquel due to her Anxiety. R39 stated, Sometimes at night I get anxious, and the medicine is supposed to help me with feeling anxious.</p> <p>On 12/04/24 at 12:40 PM, V10 (Registered Nurse/Care Plan/Minimum Data Set Coordinator) stated that she could not provide documentation of R39's identified targeted behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's Psychotropic Medication policy (revised 11/28/17) documents the following: Intent: Residents are free from unnecessary psychotropic medication use. A psychotropic medication is any drug that affects brain activity associated with mental processes and behavior. These medications include but are not limited to: Antianxiety, Antidepressant, Antipsychotic, and Hypnotic. These medications are to be given to treat a specific condition/medical symptom that is diagnosed and documented in the clinical record. Specific condition/medical symptoms alone are not enough to justify pharmacological use. An evaluation must be done to determine other possible physical, mental, behavioral, psychological needs. This same policy documents, Residents should receive the lowest effective dose of psychotropic medication for the resident's physical, mental, and psychosocial well-being. GDR (Gradual Dose Reduction) is to be attempted within the first year in two separate quarters (with at least one month between attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. This policy also documents the following: A psychotropic medication that is used on a PRN (as needed) basis: Classification of medication including antianxiety, hypnotic, antidepressant medication. Initial PRN order of above listed medication should not exceed 14 days, unless the attending physician or prescribing practitioner believes that to extend beyond 14 days and has documented the rationale and indicated the duration. +</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50627</p> <p>Based on observation, interview and record review, the facility failed to follow Enhanced Barrier Precautions while performing wound care, perineal care, and hand hygiene for one of three residents (R39) reviewed for wound care in a sample of 33.</p> <p>Findings include:</p> <p>On 12/01/2024, at 10:45 AM, V12 (CNA/Certified Nursing Assistant) and V13 (CNA/Certified Nursing Assistant) were in R39's room changing R39's adult incontinent brief. V12 and V13 were not wearing a gown. V13 had only one glove on her right hand and was taking R39's adult incontinence brief off with the assistance of V12. V13 left the room briefly, and once V13 re-entered R39's room, she did not apply a gown, and only applied a glove to her right hand. After cares were completed, V12 and V13 removed their gloves, washed their hands, and proceeded to place R39 into a mechanical lift and assisted her to transfer into her wheelchair. V12 and V13 did not apply a gown or gloves prior to transferring R39.</p> <p>On 12/01/2024, at 11:00 AM, V13 stated that R39 was currently on Enhanced Barrier Precautions, due to a burn on her thigh. At this same time, V12 and V13 both stated that they should have been wearing a gown throughout R39's cares. V13 then stated she should have been wearing both of her gloves while providing cares to R39.</p> <p>On 12/04/24 at 08:58 AM, V11 (Licensed Practical Nurse) entered R39's room to provide a dressing change and wound care to R39's left thigh wound. V11 washed her hands, and donned gloves, but did not apply a gown before performing R39's wound care and dressing change.</p> <p>On 12/04/2024 at 09:15 AM, V11 confirmed that R39 was currently on Enhanced Barrier Precautions. V11 verified she did not wear a gown during R39's wound care and stated she should have.</p> <p>On 12/04/2024 at 12:40 PM, V2 (Director of Nursing) stated that staff should be wearing the required PPE (personal protective equipment) when providing care to residents in Enhanced Barrier Precautions. V2 then stated, There is no excuse, they should have been wearing gloves and a gown.</p> <p>The Facility's Enhanced Barrier Precautions Protocol Policy, revised 4/8/24, documents, Enhanced Barrier Precautions expands the use of Personal Protective Equipment (PPE) beyond situations in which exposure to blood and body fluids is anticipated, refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of Multi-Drug-Resistant Organisms (MDROs) to staff hands and clothing. If Enhanced Barrier Precautions are required, a sign should be placed outside the resident's room to assist in educating staff, residents, and visitors on appropriate personal protection. When required, Enhanced Barrier Precautions apply to everyone caring for the resident. This same policy documents, Personal Protective Equipment, PPE (e.g., gloves and gowns) should be used during high-contact resident care activities. Examples of high-contact resident care activities requiring gowns and glove use include Wound care: any skin opening a dressing. This policy also documents, Enhance Barrier Precautions may be indicated for residents with any of the following: Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or tears covered with an adhesive bandage (e.g., Band Aid) or similar dressing.</p>		