STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altoona Nursing and Rehabilitation Center	200 Seventh Avenue SW Altoona, IA 50009

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 25854 Based on observation, clinical record review, staff interview, resident interview, Resident Council Minutes and facility policy review, the facility failed to properly provide perineal cares for random residents and failed to provide baths/showers to residents according to their individual desires and/or needs. (Resident #2) The facility identified a census of 87 residents. Findings include: 1. During an interview 7.31.24 at 9:50 a.m. Staff F, Certified Nursing Assistant (CNA) confirmed there had been times she found residents in bed with their disposable undergarments wet all the way through their bedding completely soiled with sheets that showed signs of dried urine as noted by a dried dark circle around the wet urine which signified the resident had not been changed for a lengthy period of time. During an interview 8.1.24 at 10:43 a.m. Staff M, CNA/Shower aide confirmed she had not been able to shower residents according to their individual schedules due to staffing issues and that many residents complained however she had been unable to give specific names. The staff member also confirmed when she assisted resident's in the morning to get up for their baths and also periodically through the day she found them with dried stool on various body parts and completely soiled with urine through their bedding which consisted of a fitted sheet, turn sheet, washable chux pad and a brief. During an interview 8.5.24 at 1:04 p.m. Staff N, CNA confirmed there had been times she found residents completely soiled through their disposable undergarments and their bedding. The staff member described the bedding with dried urine stains due to a dark ring around the urine. 2. A Significant Change Minimum Data Set (MDS) assessment form dated 5.30.24 indicated Resident # 2 had diagnosis that included a Neurogenic Bladder, Urinary Tract Infections (UTI) and Arthritis. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (cognitively intact) and required staff assistance with most activities of daily living (ADL's). A Care Plan with a Problem area of self-care deficit as evidenced by required assistance with ADL's, impaired balance during transitions and required assistance for ambulation and incontinence. The Interventions included the following: a. One (1) person staff assistance with encouragement of bathing two times a week (BID). (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to a facility task form for bathing/showering dated 3.29.24 thru 7.26.24 revealed the facility failed to bath the resident on the following dates: a. 4.2, 4.20 thru 4.21, 4.30, 5.2, 5.19, 6.5 thru 6.6, 6.15 thru 6.19, 6.24, 7.7 and 7.14. During an interview 7.30.24 at 2:47 p.m. the resident confirmed staff failed to bath/shower her as scheduled. The resident indicated there had been times she refused because the shower room had been cold and staff refused to dry her hair as they stated they had no time. The resident also confirmed staff failed to offer her bed/chair baths as an alternative method. Review of the facilities Resident Council Minutes included the following concerns as dated: a. 2.15.24 - The shower aid having been pulled to work on the floor rather than baths/showers. b. 4.11.24 - Complaints of bathroom care on the 2 p.m. until 10 p.m. shifts. 3. A Bath, Shower/Tub policy form revised February 2018 indicated the Purpose of the procedure had been to promote cleanliness, provision of comfort and to have observed the resident's skin condition. Staff had been directed to document the date and time of the bath performed and if a resident refused the bath the policy directed the staff to have documented the reason(s) why and interventions taken. A Bed, Making an Occupied policy revised February 2018 indicated the Purpose of the procedure had been to provide the resident with a clean and comfortable environment with prevention of skin irritation and breakdown. A Perineal Care policy revised February 2018 indicated the Purpose of the procedure had been a means to provide cleanliness and comfort to the resident, preventions of infections and skin irritations and observance of the resident's skin.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 25854 Based on clinical record review, resident interview and staff interview the facility failed to provide restorative exercises according to the resident's individual plan of care for 2 of 3 residents reviewed. (Resident #2 and #5) The facility identified a census of 87 residents. Findings include: 1. According to an email 8.6.24 at 9:54 a.m. the Administrator indicated residents on the restorative program should have received their exercises 3-6 times per week. 2. A Significant Change Minimum Data Set (MDS) assessment form dated 5.30.24 indicated Resident # 2 had diagnosis that included a Neurogenic Bladder, Urinary Tract Infections (UTI) and Arthritis. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (cognitively intact) and required staff assistance with most activities of daily living (ADL's). The MDS documented that the resident had three days of occupational and physical therapy with the start date of 5/15/24 to end date 5/28/24. Review of restorative records dated 7.4.24 through 8.1.24 for Resident #2 directed the facility staff to have provided bilateral lower extremities (BLE) exercises times (x) 15 repetitions with a 2 pound (lb) ankle weight and to have stood the resident with a front wheeled walker (FWW) as tolerated. The facility failed to provide the exercises on the following dates: a. Weighted leg lift exercises - 7.5 thru 7.15, 7.18 and 7.20 thru 8.1. b. Standing exercises - 7.5 thru 7.15, 7.18, 7.20 thru 7.28 and 7.31. 3. During an interview 8.1.24 at 2:41 p.m. the Resident#2 confirmed staff failed to provide restorative exercises as set up. Review of restorative records dated 7.3.24 thru 8.1.24 for Resident #5 directed the facility staff to have provided bilateral upper extremity (BUE) exercises x 15 repetitions with a 1 lb dumbbell x 2 sets and BLE marches, hip flexion, abduction and ankle pumps x 15 repetitions x 2 sets as tolerated. The facility failed to provide the exercises on the following dates: a. BUE exercises - 7.3, 7.6 thru 7.12, 7.14 thru 7.15, 7.18, 7.20 thru 7.25 and 7.30 thru 8.1. b. BLE exercises - 7.3, 7.4, 7.6 thru 7.7, 7.9, 7.14 thru 7.15, 7.18, 7.24 thru 7.25, 7.29 thru 7.30 and 8.1.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 25854 Based on observation, clinical record review, staff interview and facility policy review the facility failed to ensure staff maintained a safe and secure environment for 1 of 3 residents at an elopement risk. (Resident #4) The facility identified a census of 87 residents. Findings include: A Quarterly Minimum Data Set (MDS) assessment form dated 6.11.24 indicated Resident #4 had diagnosis that included Hypertension (HTN), Non-Alzheimer's Dementia, Depression and repeated falls. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 (moderately impaired cognitive skills) and independent with ambulation. A Care Plan addressed the following Problem areas and Interventions as dated: a. A self-care deficit as evidenced by required staff assistance with activities of daily living (ADL's), impaired balance during transitions and required assistance for ambulation. (revised 3.8.24). 1. One (1) staff assistance with transfers and mobility. (revised 3.8.24) b. At risk for falls related to (r/t) impaired balance, poor safety awareness, neuromuscular/functional impairment and/or the use of medications that may have increased her fall risk r/t a diagnosis of recurrent falls, HTN and Osteoporosis. (revised 3.8.24) 2. The resident required a safe environment with even floors free from spills and/or clutter, adequate lighting and items in personal reach. (revised 3.8.24) c. At risk for injury d/t wandered. (initiated 3.12.24 and revised on 7.10.24 as on 7.4.24 the resident removed her wander guard device). d. Assistance to high traffic areas during ambulation or in wheel chair for assurance of frequent visualization. (imitated 3.12.24) e. Impaired cognitive function and/or thought processes as evidence by short/long term memory deficits, impaired decision making and/or impaired mobility to understand others r/t a diagnosis of Dementia. (revised 3.12.24) An Elopement Assessment form dated 6.11.24 at 4:27 p.m. indicated the resident as at an elopement risk. A Fall Assessment form dated 6.11.24 at 5:27 p.m. indicated the resident as at a fall risk. The facilities Progress Note entries included the following as dated and timed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. 6.6.24 at 9:52 p.m. - The resident wandered up and down the hallways. b. 6.11.24 12:25 p.m.- Resident was walking in hallway without walker, education provided regarding safety with use of walker c. 6.24.24 at 2:54 p.m. - The resident had been at one of the facilities back doors as her wander guard device set off the door alarm. d. 7.4.24 at 3:08 p.m. - The resident had been found outside of the facility by dietary staff. Resident presented without her walker and wore a blue sweatshirt over a black short sleeved blue blouse, blue stretch pants and black tennis shoes. Her wander guard device had been found in the resident's bedside drawer with the band cut located beside a butter knife. A head to toe assessment had been completed as follows: blood pressure 110/63, pulse, 94, respirations 20, pulse oximetry at 95% at room air, temperature 98.1 degrees Fahrenheit, lung sounds clear to auscultation, grips strong and equal, pupils are equal, round and reactive to light and accommodation (PERRLA) and no complaints of pain. e. 7.18.24 at 4:17 p.m. - Attempted made to exit the building with the smokers but stopped by activities personnel. During an interview 7.31.24 at 9:43 a.m. Staff, E Certified Nursing Assistant (CNA) indicated she arrived to work on 7.4.24 at about 1:45 p.m. and as she disarmed the front door alarm and entered the facility the resident exited from the same door and at the same time. The staff member indicated she had not known what the resident looked like because she lived in the back part of the building and the staff member worked the North part of the building. The staff member stated, basically, they crossed in passing. The staff member indicated the resident ambulated out of the building without the use of a walker and she presented with an appearance of a visitor. The staff member indicated she had not known the resident until Staff F, CNA pulled the resident's picture up on the computer at which time she stated Oh, my God that who had been the person who went outside. The staff member indicated she heard after the event the resident had been a wanderer and moved fast. During an interview 8.1.24 at 2 p.m. Staff J, dietary aide and Staff K, dietary aide indicated as they took the trash outside on 7.4.24 they observed the resident as she walked across the grass in the front of the building by the trees and towards the cars without the use of her walker. The two (2) staff members indicated Staff L, CNA and Staff I, CNA also walked outside just behind them to take out their trash as well when they pointed out the resident to the CNA's who redirected the resident back into the building. Staff J indicated she knew the resident because she always went to the back of the building and gave her drinks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 7.31.24 at 3:30 p.m. Staff H, Licensed Practical Nurse (LPN) indicated on 7.4.24 she answered the telephone located at the nurse's station as a CNA asked if she knew that one of her residents had been outside. The staff member responded no and went outside as she observed Staff H, CNA and Staff I, CNA as they assisted the resident back into the facility. Staff H indicated the resident took little slow steps as she returned into the facility but showed no appearance of having fallen or tiredness but rather more irritated because she wanted to go see her son. The resident had no appearance of being tired but rather more irritated because she said she was going to see, her son. Staff H had no recollection as to the last time she observed the resident that day because the resident wandered around the facility. When Staff H indicated she found the resident's wander guard device in a drawer in her bedside stand positioned right next to a butter knife. The staff member asked the resident where her walker had been located and the resident indicated she had not used it because she did not wanted people to know she required assistance of the device for ambulation. During an interview 7.31.24 at approximately 12:50 p.m. Staff H indicated she checked the functionality of the resident's wander guard system located on her person on 7.4.24 at 7:30 a.m. as documented on the resident's Treatment Administration Record (TAR) form. An observation 7.31.24 at 10:13 a.m. with the Director of Nursing (DON) revealed the wander guard system around the A hallway South [NAME] (SW) doorway failed to sound when tested and proved non-functional. This door had been located 1 door down from Resident #1. During an interview 7.31.24 at 10:20 a.m., Staff G, maintenance indicated there had been no electricity to the wander guard device located around the door. During an interview 8.1.24 at 10:08 a.m. Staff A, Certified Nursing Assistant (CNA) confirmed she had orientated to which resident's wandered and/or who had been an elopement risk and had not been aware of any elopement books in the facility. During an interview 8.1.24 at 10:11 a.m. Staff B, CNA confirmed she had not been orientated on which residents had been an elopement risk but knew if the door alarms sounded staff had been directed to respond and account for all residents. During an interview 8.1.24 at 10:15 a.m. Staff C, housekeeping indicated if a resident left the facility staff called on their personal cell phones and called the facility if they observed the resident outside but she had been unaware which residents posed an elopement risk. During an interview 8.1.24 at 10:25 p.m. Staff D, Registered Nurse (RN) indicated she had not been educated on the facilities elopement policy on hire, which residents at risk for elopement and who wore a wander guard device. The staff member also confirmed she had no knowledge of where the elopement books had been located. The facilities 2.6.2023 Elopement/Missing Resident policy's Definition of Elopement included the following: The facility defined elopement as an incident in which a resident who had impaired decision-making ability left the facility without the knowledge or supervision of staff.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 25854 Based on observation, photos and facility policy review the facility failed to maintain a locked treatment cart on two (2) separate occasions. The facility identified a census of 87 residents: Findings include: An observation 7.30.24 at 4:46 p.m. revealed an unlocked and unattended treatment cart located along the wall outside of room N6. An observation 8.1.24 at 2:32 p.m. revealed an unlocked and unattended treatment cart located along the wall just outside of room A46. The facility had identified 8 residents who wandered. According to an email 8.6.24 at 3:56 p.m. the Administrator confirmed she expected staff to have locked medication and treatment carts when unattended. A Security of a Medication Cart policy not dated indicated the medication carts should have been secured during medication passes. The Policy Interpretation and Implementation included the following: a. The nurse must have secured the medication cart during the medication pass for prevention of an unauthorized entry. b. When it had not been possible to park the medication cart in the doorway, the cart should have been parked in the hallway against the wall as the doors and drawers faced the wall. The cart must remained locked before the nurse entered the resident's room. c. Medication carts remained securely locked at all times when out of the nurse's view.