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	06/26/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interviews, staff interviews and policy review, the facility failed to provide comfortable and safe temperature levels in the building for one of two dinning rooms. The facility reported a census of 90 residents. Findings include: During an observation on 6/23/25 at 1:10 PM the back dining room area thermostat read 83 degrees. The dining room was uncomfortably warm, staff in the dining room and residents in the dining room waiting to go outside to smoke had flushed faces and staff had sweat on their faces. There were two fans in the dining area. During an interview 6/23/15 at 1:15 PM Staff A, Licensed Practical Nurse (LPN), stated the air conditioning unit in the dining room kept freezing up and quitting this weekend and it was even hotter in the dining room this weekend, on Sunday. She called the Director of Nursing (DON) on Sunday, they were unable to get someone out to fix it on Sunday, the unit was out all day on Sunday and the temperature in the dining room was in the high 80's. Staff A stated it was very uncomfortable on Sunday in the dining room and continues to be uncomfortable. Staff A stated each resident has their own air conditioning unit in their bedroom, and they can control their room temperature. Staff A stated the residents had the option of eating in their room or staying in the dining room to eat, they had residents eating in the dining room for all three meals yesterday and for breakfast and lunch today. During an interview 6/23/25 at 1:50 PM the DON and Administrator stated the building is [AGE] years old and has boiler heat. The building does not have central air conditioning, each resident room has a window air conditioning unit. The hallways are cooled by the air conditioning units in the resident's rooms. The two dining rooms have a dual unit on the wall which provides heat and air conditioning. The DON stated she received a call this weekend, on Sunday, that the unit in the back dining room was not working. They could not get a company in to look at it until this morning, the unit was frozen. They said the worker had to wait for it to thaw which would take a few hours and they hope to have it working by the end of the day. The DON and Administrator acknowledged the back dining room has not had a working air conditioning unit since Sunday morning. There are fans in the dining room and residents have eaten in the dining room, they also have the option to eat in their rooms. The DON and Administrator acknowledged it was hot in the back dining room. Both stated there had not been another plan in place to cool the dining room while the unit is being repaired and the dining room is still being used. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview 6/23/25 at 2:30 PM Staff C, maintenance, stated he received a call on Sunday that the back dining room was hot and the unit did not seem to be working. Staff C came to the facility on Sunday and the air conditioning unit in the back dining room was not working, the unit was frozen. Staff C called a company to come out yesterday but the soonest anyone could come out was today (Monday), they said they would be here first thing in the morning. The company went to the wrong building so Staff C called another company who came out late this morning. The unit was frozen, they have to wait for it to thaw and then they will determine if they need to replace any parts. They will have it working again today. The unit was repaired and working at 4:30 PM on 6/23/25. During an interview 6/24/25 at 8:10 AM Staff B, dietary staff, stated she worked on Sunday, the 22nd of June, and the air conditioning unit was not working in the back dining room. Staff B works in the back dining room. They called maintenance on Sunday, however the air conditioning unit was not fixed until yesterday late afternoon. Staff B felt the temperature in the dining room on Sunday was in the high 80's or low 90's by the end of the day. She said most residents chose to eat dinner in their rooms as the dining room was so hot, however they had residents who ate all three meals in the dining room. They had fans, but it did not cool off the dining room. Staff B stated it had never been this hot in the dining room. During an interview 6/24/25 at 7:39 AM Staff D, LPN, stated the back dining room is so hot, this morning the temperature in the dining room was 81 degrees. Staff D stated my skin was tingly hot yesterday. Staff D stated the back dining room the past few days has been between 81 - 83 degrees and said everyone is hot. Staff D stated they use the airconditioners in resident rooms to cool the facility since the air unit is broken in the dining room. During an interview 6/24/25 at 8:48 AM, the Administrator acknowledged the temperature was too warm in the back dining room on Sunday and during the morning and afternoon yesterday. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #8 documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. During an interview/observation 6/24/25 at 9:10 AM Resident #8 stated thank you for getting us air in here, it was hot over this weekend. Resident #8 just had a sheet covering him, no clothes and a small fan blowing onto him. The MDS assessment dated [DATE] for Resident #12 documented a BIMS score of 15, indicating intact cognition. During an interview 6/24/25 at 11:20 AM, Resident #12 stated this past weekend the air conditioning unit in the back dining room where she eats quit working. She said on Sunday it was so hot in the dining room, it felt like it was 500 degrees there. She said she had sweat on her face and her body when she was in the dining room eating on Sunday and for breakfast and lunch on Monday. She ate breakfast, lunch and dinner in the dining room on Sunday and she was so hot she lost her appetite and did not eat all of her food. She had plenty of fluids. She did not stay in the dining room long as she wanted to go back to her room to cool off. The air conditioning unit in her room always works. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview 6/24/25 at 2:21 PM, Staff E, Certified Medical Assistant (CMA), stated she worked on Sunday (the 22nd of June) and the air conditioning unit was not working in the back dining room. During lunch on Sunday she took a resident back to their room as it was so hot the resident said they could not eat in the heat and finished her lunch in her room. The resident has Chronic Obstructive Pulmonary Disease (COPD) and was uncomfortable in the dining room. Staff E stated it was so hot on Sunday in the dining room. Review of the facility Quality of Life-Homelike Environment policy, with a revision date of May 2027, documented residents are provided with a safe, clean, comfortable and homelike environment with comfortable and safe temperatures (71°F - 81°F).

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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. Based on clinical record review, medication administration log, staff interview, and facility policy review, the facility failed to prepare or administer medication as prescribed and ordered by the physician for 2 of 3 residents reviewed (Resident #2, #7). The facility reported a census of 90. Findings include: 1. The Annual Minimum data set (MDS) for Resident #2, dated 05/14/2025, documented her brief interview for mental status (BIMS) score as 15, indicating fully intact cognition. It documented the following relevant diagnoses: anemia (low blood iron), renal insufficiency (kidney failure), and Diabetes Mellitus (Diabetes). Review of the Care Plan for Resident #2, last revised on 05/21/2025, recorded the resident's diabetic status and instructed staff members to give medications as ordered by doctor. It also instructed staff members to monitor the resident for signs of hyperglycemia and hypoglycemia (high and low blood sugar). It instructed staff members to document side effects and effectiveness. Review of the medication and treatment administration records (MAR and TAR), from 01/01/2025 to 06/23/2025 revealed the following: Resident #2 had an order for Insulin Lispro Subcutaneous Solution Cartridge 100 UNIT/ML to be administered three times a day via a sliding scale. Morning, Noon, and Evening. Resident #2 had an order for Lantus Subcutaneous Solution 100 UNIT/ML to be administered twice a day. Morning and Evening. On 05/08/2025 the MAR lacked documentation for Insulin Lispro subcutaneous injection (Insulin Lispro) on the evening administration. On 05/11/2025 the MAR lacked documentation for Insulin Lispro on the evening administration. On 05/15/2025 the MAR lacked documentation for Insulin Lispro on the evening administration. On 05/23/2025 the MAR lacked documentation for Insulin Lispro during the morning and noon administration. On 05/31/2025 the MAR lacked documentation for Insulin Lispro during the evening administration. On 06/10/2025 the MAR lacked documentation for Insulin Lispro during the evening administration. On 05/08/2025 the MAR lacked documentation for Lantus Subcutaneous Solution (Insulin Glargine) during the evening administration. On 05/23/2025 the MAR lacked documentation for Insulin Glargine on the morning administration. On 05/31/2025 the MAR lacked documentation for Insulin Glargine on the evening administration. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The missing documentation corresponded to higher blood sugar readings following the missing administration on 05/08/2025, 05/11/2025, 05/15/2025 where the next blood sugar was recorded as 400, and 05/23/2025 where the next recorded blood sugar was 320. In an interview on 06/25/2025 at 08:28 AM with Resident #2, she stated she had missed at least three doses in the last month of her evening insulin. She stated that on numerous other occasions she has had to track down a nurse and remind them she required her insulin. She stated even when she gets her insulin she feels it is given late. She stated when she misses her insulin she feels sick, and mentioned she had been hospitalized for high blood sugar in the distant past. She was unable to identify which nurse failed to give her the insulin, but was able to state it almost always occurs during the evening administration of her medication. 2. The Quarterly MDS for Resident #7, dated 04/24/2025, documented his BIMS as 15, indicating fully intact cognition. It failed to document the resident's diagnoses of glaucoma. Review of Resident #7's Care Plan, last revised on 05/07/2025, warned staff members he had impaired vision due to a diagnosis of glaucoma and macular degeneration. It instructed staff members to administer medication and eye drops as ordered and document decreased visual function. Review of the MAR and TAR for Resident #7 documented the following: Resident #7 was prescribed Latanoprost PF Ophthalmic Solution 0.005 % (Latanoprost) once daily before bed. The Latanoprost was marked as unavailable and not administered on the following dates. 04/26/2025 04/27/2025 04/29/2025 04/30/2025 05/01/2025 05/02/2025 05/03/2025 05/04/2025 05/05/2025 06/06/2025 In an interview on 06/24/2025 at 10:57 AM with Resident #7, he stated the staff had told him his eye drops were unavailable for at least a week in May or April, and during that time his eyes hurt and bothered him. He was unsure why one nurse would find the medication only for the nurse the next day to be unable to find it. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/26/2025 at 11:11 AM with Staff D, Licensed Practical Nurse (LPN), she was able to accurately state the process for providing medications to a resident. She stated she would never assume a medication was given it was not documented as given in the MAR. She stated if she noticed a medication was unavailable or was not documented on she would contact the nurse who marked it or failed to mark it and then speak with management. She was unfamiliar with residents missing eye drops or insulin injections. In an interview on 06/26/2025 at 11:22 AM with Staff F, Registered Nurse (RN), she stated all medication is required to be documented in the MAR, and if the medication was not given or otherwise missed she would contact the physician or provider for further instructions. She stated if a medication is unavailable it is their job to contact the pharmacy and get a medication as soon as possible. In an interview on 06/25/2025 at 12:15 PM with the Director of Nursing (DON) she stated she had been aware of a resident reporting several missing doses of medication. She confirmed the only place staff members document medications is in the MAR. She stated her expectation is for staff members to give medications as ordered. A policy covering the accuracy of medication administration was asked for but unavailable.