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	04/11/2024

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47582 Based on clinical record review, family interview, staff interview, and the facility policy review, the facility failed to promptly notify resident representative when there was a room change with resident health changes for 1 of 1 residents (Residents #242) reviewed. The facility reported a census of 89 residents. Findings include: Review of the Minimum Data Set (MDS) for Resident #242 dated 4/05/2024 documented an admitted [DATE]. The MDS documented the resident had a Brief Interview of Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The Clinical Record Review of Resident #242 indicated having a family member, daughter, involved in discussions about health status and changes from the date of the admission. During an interview on 4/11/24 at 12:30 PM with Resident #242 daughter, it was revealed that the facility did not notify her of the room change. During an interview on 4/11/24 at 2:30 PM with the Administrator, she confirmed that the facility failed to notify Resident #242 representative prior to a room change. Review of a facility provided policy titled Room Change/Roommate Assignment revised on March 2021 documented: 4. Notification will occur prior a change in room or roommate assignment.

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 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. 33878 Based on observations, resident statements, staff interview and facility policy review, the facility failed to contain odors, wipe soiled surfaces and clear cluttered hallways to promote a homelike environment. The facility reported a census of 89 residents. Findings include: Observation on 04/10/24 at 08:55 AM revealed a strong, very pungent ammonia / urine odor from the dirty linens present in A Hallway. Odor first noted outside of room A40. A fan on the wall near the ceiling blew down on the dirty linen and the trash containers which were covered. The urine odor continued to the next room outside of room A42 which also contained a barrel labeled trash only - 33 gallon bin. The strong urine smell continued past room A44 and A46 where the smell dissipated near the nurses station. The linen bin contained a half full clear trash bag lining which was visible as the zipper not zipped up on the outside cloth liner. Soiled bed incontinence pads could be seen within the linen bin. Observation on 04/10/24 at 09:06 AM revealed the presence of a strong, very pungent ammonia smell outside of room W34 which continued up the [NAME] Hallway to room W32. Observation on 04/10/24 at 09:35 AM on A Hallway revealed the strong urine odor remained from room A42 to A44. Observation on 04/10/24 at 09:43 AM on North Hallway revealed the presence of a strong bowel / feces odor from room N6 to N10. A dirty linen / trash cart present outside of room N6. The zipper outside liner not zipped and the linen clear bag observed to be 3/4th full with incontinence pads inside. Observation on 04/11/24 at 08:55 AM revealed the presence of a strong, very pungent ammonia smell outside of room W34 to W32. Observation on 04/11/24 at 08:59 AM revealed the [NAME] Hallway lined from room W31 to the maintenance room / W25 with a mechanical lift machine, 2 wheelchairs, weight scale chair, trash / linen bin, and room tray cart. On the other side of the hallway outside of room W28, the Assistant Director of Nursing (ADON) present with a medication cart. The random observation revealed 5 residents lined up in wheelchairs attempting to get through. The ADON stated to the first resident next to her medication cart he needed to move; no attempts were made by the ADON to move her medication cart instead. Several residents made the comment that they had a traffic jam and others commented they were trying to go smoke but couldn't get through. The facility policy titled Quality of Life - Homelike Environment revised May 2017 included the following documentation: Point 2 - The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Clean, sanitary and orderly environment f. Pleasant, neutral scents Point 3 - The facility staff and management shall minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics include: b. Institutional odors d. Medication carts 46873 3. On 4/8/24 at 2:26 pm, it was noted during observation that B hall was extremely cluttered. Laundry carts, wheelchairs, walkers, and mechanical lifts were all stored in the hallway taking up most of the length of the hallway on one side. On 4/8/24 at 2:46 pm, Resident #66 was observed attempting to self propel his wheelchair out of his room. There were two stand up mechanical lifts and a walker to his right side as he exited the room. The wheel of the walker was noted to be obstructing the pathway of the exit of his room. A full body mechanical lift and a wheelchair were to his left. The resident was overhead stating Pretty soon I won't be able to get out of here at all. 47582 On 04/11/24 at 12:30 PM an observation of room N8 on North Hall revealed 2 hand-size stains on the bathroom door and the door trim of dark brown color. The stains appeared to be smeared across both surfaces. During an interview with Staff V, Housekeeping Aide, on 04/11/24 at 02:01 PM she confirmed room N8 bathroom door and the trim appeared to be soiled with fecal matter on both surfaces.

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	165162	A. Building B. Wing	04/11/2024

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 46873 Based on clinical record review and staff interview, the facility failed notify the long term care ombudsman for resident transfers to an acute care hospital for 1 of 4 residents reviewed for rehospitalization (Resident #44). Findings include: The census line of the Electronic Health Record of Resident #44 reflected the resident was on an unpaid hospital leave from 1/3/24 through 1/10/24. The General Progress Note dated 1/3/24 at 5:30 pm reflected the resident was making suicidal statements in a conversation with the Social Worker. The progress note documented the social worker reported this to the Director of Nursing and was instructed to call 911 and the resident was sent to the hospital at approximately 5:30 pm. The Admission Assessment note dated 1/10/24 reflected the resident returned to the facility on that date. The Notice of Transfer Form to Long Term Care Ombudsman with an email date of 2/5/24 failed to document resident #44 to be included on the list of residents reported to the Ombudsman to have transferred from the facility in January 2024. On 4/10/24 at 1:53 pm, the Social Services Director stated she runs a report of discharges and transfers for when she ran the report Resident #44 was not included on the report. She stated she could tell by looking at the census line of the resident that it had been revised in March of 2024. She stated there was possibly and incorrect action code which may have been done which could have effected the report. She further stated the business office enters the action code and she could see if it had since been revised. On 4/10/24 at 2:29 pm, the Business Office Manager (BOM) stated the resident's 1/3/24 discharge to the hospital was entered on his census line on 1/4/24. She stated that at times, Point Click Care (PCC, the Electronic Health Record software program) freezes and so then the census line will need updated. She said that if a clinical employee (such as a floor nurse) enters something, she will then go into the system to update it to make sure it was entered correctly. She stated she did not recall that exact discharge, but there may have been an issue with an incorrect entry so she may have deleted and entry and re-entered it the correct way. The BOM clarified she did not believe the census line had changed, but his rate line, which is strictly for billing did change as his reimbursement rate from Medicaid had changed. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/24 at 4:48 pm, The Social Services Director provided a photocopy of a screenshot showing the census line of Resident #44 was created on 1/22/24 by the BOM and was revised on 3/6/24 by a corporate employee. She stated after these modifications, when the discharge report was ran, Resident #44 showed up on the report. When she ran the report at the time of the ombudsman notification, his name did not show up. She stated this was due to modifications made in the census line portion of the resident Electronic Health Record. On 4/10/24 at 8:56 am via email, the Administrator stated the facility did not have a policy for ombudsman notification. She stated the facility sends the discharge information to the ombudsman on a monthly basis.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33878 Based on clinical record review, observation, and staff interview, the facility failed to accurately code resident MDS (Minimum Data Set) assessments to reflect accurate resident conditions for 2 of 18 sampled residents (Resident #2, #47). Resident #2 inaccurately coded as having no PASRR (Preadmission Screening and Resident Review) level II evaluation and Resident #47 inaccurately coded for the use of bed rail restraint. The facility reported a census of 89 residents. Findings include: 1. The Annual MDS assessment dated [DATE] for Resident #2 documented the resident was not considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. The MDS recorded no response under Level II PASRR conditions: Serious Mental Illness, Intellectual Disability, or Other related conditions. The MDS documented active diagnoses that included psychiatric / mood disorders of: anxiety, depression, bipolar depression, psychotic disorder, and schizophrenia. The MDS marked the resident as taking an antipsychotic medication on a routine basis. The Quarterly MDS assessment dated [DATE] coded the use of antipsychotic medication on a routine basis. The Progress Notes dated 6/8/23 at 8:13 PM recorded a note from the Advanced Practice Registered Nurse (APRN). The entry recorded the resident had a prior history of cerebral palsy with schizoaffective disorder. The entry documented the resident took Risperidone (antipsychotic). The Active Physician Order Tab in the Electronic Health Record (EHR) documented active orders for: psychological services on 1/2/24; antipsychotic medication Risperidone on 6/12/23 which remained active as of 3/20/24. Record review conducted on 04/10/24 at 09:53 AM revealed Resident #2's miscellaneous chart information contained a PASRR level II documentation on completed on 3/8/23. The PASRR documented the evaluation and determination as approved with Specialized Services. Observation on 04/10/24 at 11:23 AM revealed Resident # 2 displayed behaviors of screaming and refusing cares. On 04/11/24 at 09:05 AM the Assistant Director of Nursing (ADON) responded that the MDS Coordinator was from corporate so likely not in the building yet that day. The ADON voiced she didn't always see or know when the MDS Coordinator was in the building as they do use several traveling MDS Coordinators. On 04/11/24 at 01:48 PM the DON responded the MDS Coordinator worked remote and in the facility 3 times a week. 50118 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS assessment dated [DATE] for R #47 indicated bed rails used daily. The Care Plan dated 3/8/24 lacked documentation pertaining to the use of bed side rails. The clinical record lacked documentation of a bed side rail assessment. During interview with R #47's son conducted on 04/09/24 at 10:14 AM, the son indicated he was not aware of any bed rails being used for his mother and they had not been discussed with him. He did indicate that his mom was supposed to have a new bed on 04/10/24 at 11:38 AM. Observations of R #47's bedroom on 4/8/24, 4/9/24, and 4/10/24 revealed no bed rails installed on the resident's bed. On 04/10/24 at 11:15 AM, Staff C, MDS Coordinator, indicated bed rails were incorrectly coded on section P of the MDS. Staff C confirmed that Resident # 47 has not had bed rails and she did not have them at the time of survey. Staff C further indicated that another MDS Coordinator who was in training completed the MDS for R #47. Staff C also indicated if R #47 would have had bed rails, a bed rail assessment would have been completed. Staff C corrected section P of the MDS from 2/22/24 for R #47 and said she would let the other coordinator know about the error and correction. Per record review of the MDS on 4/10/24 at 11:48 AM, the surveyor confirmed the MDS was corrected by Staff C at 11:11 AM on 04/10/24 and the MDS no longer indicated that R # 47 needed bed rails daily.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, staff interview, and policy review, the facility failed to update and revise the Care Plan to reflect therapy recommendations of resident restorative activities program for three of three sampled residents in order to maintain a functional range of motion and activities of daily living (Residents #19, #28, and #44). The facility reported a census of 89 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had diagnoses of congestive heart failure (CHF), chronic kidney disease, and cancer. The MDS revealed Resident #19 independent with bed mobility, toileting and transfers. The MDS indicated the resident not steady but able to stabilize without staff assistance when she moved from a seated to standing position and when transferred between the bed and chair or the wheelchair. The MDS recorded the resident's range of motion (ROM) not impaired. The resident had Occupational Therapy (OT) 12/20/22 to 1/10/23, and Physical Therapy (PT) 1/2/23 to 1/11/23, and restorative nursing program (RNP) for 0 days during the 7 day look-back period. The Annual MDS assessment dated [DATE] revealed the resident independent with bed mobility, toileting, and transfers. The MDS recorded no therapy services and O days RNP during the MDS look-back period. The Care Plan revised on 3/13/24 revealed the resident had a potential for self-care deficit and on hospice services. The Care Plan revealed the resident independent with toileting and transfers, and able to self-propel a wheelchair. The Care Plan directives included PT and OT evaluation and treatment as ordered (added to the care plan on 7/19/23). The Care Plan lacked information regarding RNP. The OT discharge summary dated 1/11/23 revealed the resident had diagnoses of influenza, respiratory syncytial virus (RSV), muscle weakness, and needed assistance with personal care. The OT summary documented the resident discharged from OT on 1/10/23. The OT recommendations included a RNP and Range of Motion (ROM) program. The OT discharge summary documented team communication/collaboration as follows; reviewed patient's plan of treatment services with interdisciplinary team members. The PT Discharge Summary dated 1/11/23 revealed the resident able to ambulate safely on a level surface up to 10 feet using a 2- wheeled walker and contact guard assist (CGA). The PT recommendations included a RNP and noted resident prognosis good with consistent staff follow through. The PT Discharge Recommendations included the following; Restorative Program Established/Trained= other restorative program (seated strengthening exercises, omnicycle, gait with front wheeled walker up to patients tolerance. The Restorative Nursing Program (RNP) document dated 1/11/23 revealed a sticky note labeled hospice on top of the document. The RNP included the following: a. Ambulation with FWW (front wheeled walker) as tolerated (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Lower extremity (LE) ankle pumps, seated LE long arc quads, and hip flexion exercises c. Standing LE exercises: plantar, hamstring curls, and marches d. Passive range of motion (PROM) seated reaching and standing reaching. e. Upper extremity (UE) shoulder flexion, abduction, internal/external rotation, elbow flexion/extension, and hand/fingers PROM. On 4/10/24 at 10:45 AM, the Director of Nursing (DON) reported some restorative documentation on computer under tasks, and some restorative activities documented on paper. The facility transitioned from paper to computer several months ago but she was unable to recall the exact month/date of the transition. She entered the residents' restorative activities program into the EHR, and thought she did this around 7/2023. If a resident on a restorative program it would be listed on the Care Plan. At the time, the DON reported Resident #19 on hospice and she didn't think she had restorative. The DON checked Resident #19's EHR and Care Plan and reported no restorative program listed on the resident's care plan. On 4/10/24 at 12:45 PM Staff L, Therapy, confirmed Resident #19 had therapy services and discharged from therapy on 1/10/23 with recommendations for RNP. Staff L reported a restorative exercise program was developed and provided to the DON. In an interview on 4/10/24 at 3:30 PM, the DON provided a list of residents who had restorative activities program but she missed entering those residents into the computer when the facility transitioned from paper to EHR. The DON reported since information not entered staff didn't know to do restorative exercises with the resident. Review of the list revealed Resident #19 listed on the document for a walk to dine program with stand by assistance, BLE (bilateral lower extremity) 2 pound ankle weights seated/reaching and stand/reaching. A Restorative Nursing Services policy revised 7/2017 revealed residents received restorative nursing care to help promote optimal safety and independence. Restorative goals and objectives are resident-centered and outlined in the resident's care plan. 2. The Quarterly MDS dated [DATE] revealed the Resident #28 had diagnoses of stroke, spastic hemiplegia, and chronic pain syndrome. The MDS indicated the resident had impaired ROM bilateral upper extremities and impaired ROM to lower extremities on one side. The MDS documented the resident had dependence on staff for eating, transfers, toileting, and bed mobility. The MDS revealed the resident had no therapy services, and listed 0 days RNP during the MDS look-back period. The Care Plan revised 1/16/24 revealed Resident #28 had a mobility deficit associated with a diagnoses of CVA (stroke) with right sided hemiplegia (paralysis on one side), and upper and lower extremities contractures. The resident required assistance with ADL's, bed mobility, and transfers. The Care Plan directives included PT and OT evaluation and treatment as ordered. The Care Plan lacked information regarding a RNP. During observation on 4/9/24 at 12:53 PM, resident sat in broda chair and had contractures to his hands and legs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/24 at 10:25 AM, two white binders labeled Restorative 2022 and 2023 located at the Front nurse's station. The binder had restorative programs for each resident on a RNP. Resident #28 had a RNP dated 7/13/23. The RNP dated 7/13/23 documented restorative activity program as tolerated including reaching activities seated in the wheelchair with stand-by assistance using bean bags and cones up to 15 minutes on the left upper extremity (UE), and shoulder, elbow, and hands/fingers passive range of motion (PROM). The OT discharge summary dated 7/13/23 revealed the resident had a diagnoses of cerebral infarction (stroke) and muscle weakness, and required personal care assistance. The OT summary documented the resident discharged from OT services on 7/13/23. The resident required CGA for eating, and PROM for contracture management. The OT recommendations included a RNP for continued strengthening and ROM exercises. Prognosis good with consistent staff follow through. The PT discharge summary dated 7/13/23 documented maximum potential achieved and resident referred for RNP. PT recommended RNP with PROM and stretching exercises to decrease stiffness and skin breakdown and decrease further contractures and spasticity. Prognosis good with consistent staff follow through. On 4/10/24 at 10:45 AM, the DON reported some restorative documentation on computer under tasks, and some restorative activities documented on paper. The facility transitioned from paper to computer several months ago but she was unable to recall the exact month/date of the transition. She entered the residents' restorative activities program into the EHR, and thought she did this around 7/2023. If a resident on a restorative program it would be listed on the care plan. At the time, the DON pulled up resident's EHR and checked the care plan. The DON reported no restorative program listed on the resident's care plan or under the tasks. The DON stated currently restorative exercises entered into the computer whenever restorative activities completed. On 4/10/24 at 12:45 PM, Staff L, therapy, reported therapy made recommendations as applicable whenever a resident completed therapy. A restorative exercise program developed and provided to the DON. Staff L confirmed Resident #28 had therapy services and discharged from therapy on 7/13/23 with recommendations for RNP. On 4/10/24 at 3:30 PM, the DON provided a list of residents she missed entering the restorative activities programs into the computer when the facility transitioned from paper to EHR. The DON confirmed no restorative documentation for Resident #28. If a resident on restorative, restorative information would be listed on the care plan. In an interview 4/10/24 at 1:25 PM, Staff M, Social Worker (SW), reported she use to work as the restorative aide but then moved to the SW role. Staff M reported she received recommendations from therapy regarding restorative program for the residents. Staff M reported Resident #28 had contractures for awhile.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 46873 Based on clinical records review, staff interviews and policy review, the facility failed to properly transcribe and implement provider orders for 1 (Resident #18) of 7 residents reviewed for medication orders. The facility reported a census of 89 residents. Findings include: The MDS of Resident #18 dated 2/21/24 identified a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. The MDS revealed the resident required substantial assistance for bed mobility. The MDS reflected the resident experienced frequent urinary incontinence. The MDS recorded the presence of one Stage 3 pressure ulcer with no pressure ulcers present upon the resident's admission to the facility, and one diabetic foot ulcer. The MDS failed to reveal the presence of of Moisture Associated Skin Damage. The Care Plan of Resident #18 revealed a focus area of self care deficit with a revision date of 10/11/23. The Care Plan noted the resident to have a history of refusing cares or assistance with cares. The Care Plan directed staff the resident required 1 person assistance with bed mobility. The Care Plan reflected Resident #18 to have a diagnosis of diabetes, and being at risk for alteration of skin related to diabetes. The Care Plan reflected a focus area of impaired skin integrity to include Moisture Associated Skin Damage, a Stage 3 pressure ulcer, and a diabetic ulcer to the left toe. A Order Entry dated 3/25/24 documented an order for a wound treatment to the right buttocks of Resident #18. The order failed to reveal a scheduled time for the treatment to be provided. The Medication Administration Record (MAR) and Treatment Administration Record (TAR) for both March and April of 2024 failed to reveal documentation of the order being placed on the MAR or the TAR. The Wound Treatment Plan from the wound specialist Advanced Registered Nurse Practitioner (ARNP) dated 3/22/24 documented Resident#18 was receiving a protein supplement to promote wound healing and that he had a foam cushion in his wheelchair. The note documented the resident spent the majority of his time in his wheelchair and reported his buttocks to be tender at times. The note further documented the wound to be described as Moisture Associated Skin Damage (MASD) measuring 4.5 x 1.1 x 0.1 centimeters (cm) and a current to treatment to cleanse with wound cleanser, apply triad paste topically every shift and as needed. The Wound Treatment Plan from the wound specialist ARNP dated 3/29/24 repeated the same narrative of buttocks being tender at times and spending the majority of the time in the wheelchair. Measurements on this visit were documented as 2.0 cm x 1.5 cm x 0.1 cm, ordering the same treatment to be continued. The Wound Treatment Plan from the wound specialist ARNP dated 4/5/24 documented the resident had a foam cushion in his wheelchair as well as a pillow on top of the cushion, along with continued tenderness to the buttock. The wound measurements were documented as 2.4 x 1.6 x 0.1 cm. Continue the same treatment. (continued on next page)

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	04/11/2024

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/24 at 9:47 am, Staff E. Registered Nurse (RN) stated she was not aware of the order for Resident #18 and on the days she had worked, she had not completed the ordered wound treatment on the resident since it had been ordered. On 4/10/24 at 12:26 pm, Staff F, Licensed Practical Nurse, (LPN), Assistance Director of Nursing (ADON) stated the normal procedure for transcribing is a triple check process. The described the triple check process as follows: a. The nurse who receives the order enters the order into the Point Click Care (PCC [the software program for the residents' Electronic Health Record]). b. The next nurse who comes on duty, verifies the order was correctly entered into PCC. c. A third nurse, normally either the Director of Nursing (DON) or the ADON will do a third check. Staff F stated that on business days, herself, the second ADON and the DON meet after morning huddle and verify all orders are transcribed into PCC. She stated she is not aware of what happened with the order. She stated at a quick glance at the order, it appeared to be entered correctly. On 4/10/24 at 3:04 pm the DON stated they look at the orders page to see if the order is there. She stated the normal practice is not to expand the order to look at the scheduled time. She stated the Certified Nurse Aides (CNAs) have a house barrier cream that they regularly use on the resident. She stated when she has rounded with the ARNP wound specialist, she has seen barrier cream in place on the wound. The facility policy Medication Orders, revision date 2014, directed the purpose of the procedure is to establish uniform guidelines in the receiving and recording of medication orders. The policy further directed When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered. The facility failed to direct the scheduling of medications.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, observation, staff interview, and policy review, the facility failed to provide restorative activities for three of three sampled residents in order to maintain a functional range of motion and prevent a decline in activities of daily living (Residents #19, #28, and #44). The facility reported a census of 89 residents. Findings include: 1. The Significant Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had diagnoses of congestive heart failure (CHF), chronic kidney disease, and cancer. The MDS revealed Resident #19 independent with bed mobility, toileting and transfers. The MDS indicated the resident not steady but able to stabilize without staff assistance when she moved from a seated to standing position and when transferred between the bed and chair or the wheelchair. The MDS recorded the resident's range of motion (ROM) not impaired. The resident had occupational therapy (OT) 12/20/22 to 1/10/23, and physical therapy (PT) 1/2/23 to 1/11/23, and restorative nursing program (RNP) for 0 days during the 7 day look-back period. The Annual MDS assessment dated [DATE] revealed the resident had a brief interview for mental status score of 12, indicating moderately impaired cognition. The MDS revealed the resident independent with bed mobility, toileting, and transfers, and recorded RNP for O days during the MDS look-back period. The Care Plan revised on 3/13/24 revealed the resident had a potential for self-care deficit and on hospice services. The Care Plan revealed the resident independent with toileting and transfers, and able to self-propel a wheelchair. The Care Plan directives included PT and OT evaluation and treatment as ordered (added to the care plan on 7/19/23). The OT discharge summary dated 1/11/23 documented the resident had diagnoses of influenza, respiratory syncytial virus (RSV), muscle weakness, and needed assistance with personal care. The OT summary documented the resident discharged from OT on 1/10/23. The resident had 3-/5 bilateral upper extremity strength and fair standing balance during ADL's (activities of daily living). The OT documented RNP established and prognosis good with consistent staff follow through. The OT recommendations included a RNP and ROM program. The PT discharge summary dated 1/11/23 revealed the resident was able to ambulate safely on a level surface up to 10 feet using a 2-wheeled walker and contact guard assist (CGA). Bilateral lower extremity strength 3+/5 on 1/2/23 and she had fair standing balance. The resident required CGA for transfers and ambulation on level surfaces. The PT recommendations included a RNP for seated strengthening exercises, omnicycle, and ambulation using a gait belt and front wheeled walker (FWW) as tolerated. Prognosis good with consistent staff follow through. The Restorative Nursing Program (RNP) dated 1/11/23 revealed a sticky note labeled hospice on top of the document. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RNP included the following: a. Ambulation with FWW as tolerated b. Lower extremity (LE) ankle pumps, seated LE long arc quads, and hip flexion exercises c. Standing LE exercises: plantar, hamstring curls, and marches d. Passive range of motion (PROM) seated reaching and standing reaching. e. Upper extremity (UE) shoulder flexion, abduction, internal/external rotation, elbow flexion/extension, and hand/fingers PROM. The documentation survey report dated 3/1 - 4/10/24 revealed no restoration activities regarding ambulation with FWW, LE ankle pumps, standing LE exercises, and upper extremity exercises. The EHR task screen revealed no restorative activity listed. The electronic health record (EHR) and paper chart lacked documentation of Resident #19's RNP exercises performed. On 4/10/24 at 10:20 AM, Staff L, Therapy, reported therapy put together restorative recommendations for the residents and gave the form to the Director of Nursing (DON). The therapy department had a binder with the residents' RNP but the nursing department also had a binder labeled restorative. During observation 4/10/24 at 10:25 AM, 2 white binders labeled Restorative 2022 and Restorative 2023 located at front nurse's station and had the residents' restorative programs inside. On 4/10/24 at 10:45 AM, the DON reported some restorative documentation on the computer under tasks, and some restorative activities documented on paper. The facility transitioned from paper to computer several months ago but she was unable to recall the exact month/date of the transition. She entered the residents' restorative activities program into the EHR, and thought she did this around 7/2023. If a resident on a restorative program it would be listed on the care plan. At the time, the DON reported Resident #19 on hospice and she didn't think she had restorative. The DON checked Resident #19's EHR and care plan and reported no restorative program listed on the resident's care plan or under the tasks. Currently, restorative exercises entered into the computer whenever restorative activities completed. On 4/10/24 at 12:45 PM Staff L, Therapy, reported therapy made recommendations as applicable whenever a resident completed therapy. A restorative exercise program developed and provided to the DON. Staff L confirmed Resident #19 had therapy services and discharged from therapy on 1/10/23 with recommendations for RNP. In an interview 4/10/24 at 1:15 PM, Staff I, Certified Medication Aide (CMA) stated she filled in and helped residents with restorative whenever the restorative aide not working. Staff I stated she was uncertain if Resident #19 had a RNP. Staff I reported a book kept at the nurse's station with the residents' RNP. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/24 at 1:25 PM Staff M, Social Worker (SW) reported she use to work as the restorative aide but then moved to the SW role. Staff M reported she received recommendations from therapy regarding restorative program for the residents. Staff M stated she didn't recall Resident #19 ever walking. Resident #19 transferred from the wheelchair to the bed or toilet but mostly sat in the wheelchair. In an interview 4/10/24 at 3:30 PM, the DON provided a list of residents who had restorative activities program but she missed entering those residents into the computer when the facility transitioned from paper to EHR. The DON reported since information not entered staff didn't know to do restorative exercises with the resident. Review of the list revealed Resident #19 listed on the document for a walk to dine program with stand by assistance, BLE (bilateral lower extremity) 2 pound ankle weights seated/reaching and stand/reaching. The DON confirmed no restorative documentation for Resident #19. A Restorative Nursing Services policy revised 7/2017 revealed residents received restorative nursing care to help promote optimal safety and independence. 2. The Admission MDS assessment dated [DATE] revealed Resident #28 had impaired ROM to the upper and lower extremities on one side. The MDS documented the resident dependent for eating, transfers, toileting, and bed mobility. The Quarterly MDS dated [DATE] revealed the resident had diagnoses of stroke, spastic hemiplegia, and chronic pain syndrome. The MDS indicated the resident had impaired ROM bilateral upper extremities and impaired ROM to lower extremities on one side. The MDS documented the resident had dependence on staff for eating, transfers, toileting, and bed mobility. The MDS revealed the resident had no therapy services, and listed 0 days RNP during the MDS look-back period. The Care Plan revised 1/16/24 revealed Resident #28 had a mobility deficit associated with a diagnoses of CVA (stroke) with right sided hemiplegia (paralysis on one side), and upper and lower extremities contractures. The resident required assistance with ADL's, bed mobility, and transfers. The Care Plan directives included PT and OT evaluation and treatment as ordered. During observation on 4/9/24 at 12:53 PM, resident sat in broda chair. Contractures observed to hands and legs. On 4/10/24 at 10:25 AM, two white binders labeled Restorative 2022 and 2023 located at the Front nurse's station. The binder had restorative programs for each resident on a RNP. Resident #28 had a RNP dated 7/13/23. The OT discharge summary dated 7/13/23 revealed the resident had a diagnoses of cerebral infarction (stroke) and muscle weakness, and required personal care assistance. The OT summary documented the resident discharged from OT services on 7/13/23. On 7/13/23, the resident required CGA for eating, and tolerated PROM up to 62 degrees to his right upper extremity. The OT recommendations included a RNP for continued strengthening and ROM exercises for contracture management. Prognosis good with consistent staff follow through. (continued on next page)

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	165162	A. Building B. Wing	04/11/2024

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The PT discharge summary dated 7/13/23 revealed maximum potential achieved and resident referred for RNP. PT recommended RNP with PROM and stretching exercises to decrease stiffness and skin breakdown and decrease further contractures and spasticity. Prognosis good with consistent staff follow through. The RNP dated 7/13/23 revealed restorative activity program as tolerated including reaching activities seated in the wheelchair with stand-by assistance using bean bags and cones up to 15 minutes on the left UE, and shoulder, elbow, and hands/fingers PROM. The EHR task screen revealed no restorative activity listed. On 4/10/24 at 10:45 AM, the DON reported some restorative documentation on computer under tasks, and some restorative activities documented on paper. The facility transitioned from paper to computer several months ago but she was unable to recall the exact month/date of the transition. She entered the residents' restorative activities program into the EHR, and thought she did this around 7/2023. If a resident on a restorative program it would be listed on the Care Plan. At the time, the DON pulled up resident's EHR and checked the Care Plan. The DON reported no restorative program listed on the resident's Care Plan or under the tasks. The DON stated currently restorative exercises entered into the computer whenever restorative activities completed. On 4/10/24 at 3:30 PM, the DON provided a list of residents she missed entering the restorative activities programs into the computer when the facility transitioned from paper to EHR. Since information not entered staff didn't know to do restorative exercises with resident. Resident #28 not listed on the document. The DON confirmed no restorative documentation for the resident. If a resident on restorative, restorative information would be listed on the care plan. In an interview 4/10/24 at 12:45 PM, Staff L, therapy, reported therapy made recommendations as applicable whenever a resident completed therapy. A restorative exercise program developed and provided to the DON. Staff L confirmed Resident #28 had therapy services and discharged from therapy on 7/13/23 with recommendations for RNP. On 4/10/24 at 1:25 PM, Staff M, SW, reported she use to work as the restorative aide but then moved to the SW role. Staff M reported she received recommendations from therapy regarding restorative program for the residents. Staff M reported Resident #28 had contractures for awhile. 46873 2. The Minimum Data Set (MDS) of Resident #44, dated 1/13/24 identified a Brief Interview of Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS reflected the resident required substantial assistance from staff to dress his upper half of his body, and was fully dependent on staff for dressing the lower half of his body and placing footwear on his body. The MDS documented substantial staff assistance for bed mobility, and full dependence for transfers. The MDS documented diagnoses that included diabetes, stroke with hemiplegia (paralysis of one side of the body), seizure disorder, schizophrenia, anxiety and depression. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan of Resident #44 documented a Focus Area of a self-care deficit requiring assistance with daily cares. The Care Plan additionally documented a Focus Area of left side hemiplegia due to a prior stroke and noted the resident to be at risk of loss of Range of Motion, contractures, muscle weakness, fatigue and decreased ability to perform Activities of Daily Living. The interventions for the Focus Area included Encourage participation in Restorative nursing program to prevent functional decline. The Kardex of Resident #44 documented three Restorative Nursing Programs. Active Range of Motion for the right upper extremity, Active Range of Motion for lower extremities and Passive Range of Motion for the upper left extremity. The Task Documentation for the three Restorative Nursing programs documented the following: Active Range of Motion, Right Upper Extremity was last documented as being completed on 1/18/2024. Active Range of Motion, Bilateral Lower Extremities was last documented as being completed on 1/9/2024. Passive Range of Motion, Left Upper Extremity was last documented as being completed on 12/21/2023. On 4/10/24 at 1:19 pm, Staff O, Certified Nurse Aide (CNA) and Restorative Aide (RA) stated the reason she has been charting the Restorative Program as Not Applicable is because the resident is currently in physical therapy. She stated a resident cannot be in both physical therapy and restorative therapy at the same time. She stated she was working the floor as a CNA on that day and not doing Restorative therapy that day. On 4/10/24 at 2:38 pm, the Business Office Manager stated Resident #44 has Medicaid only as a pay source. She stated the Resident was only approved for three therapy visits. His first therapy session was on 3/27/23 and he had one remaining appointment before he was discharged from therapy. On 4/10/24 at 3:17 pm, the Director of Nursing stated they try to not use the Restorative Aides to work the floor. She stated there had been two call ins that day so they needed to pull RA to cover the resident needs. She stated her expectation is for the Restorative Programs to be completed and documented as completed or if applicable, as refused. On 4/11/24 at 8:09 am, the Director of Therapy stated Resident #44 is currently on case load, but has only been on case load for a couple of weeks. She stated prior to this time, he was last on therapy on 11/13/23 and a restorative program was written for him at that time. The facility policy Restorative Nursing Services, revision date July 2017, documented a Policy Statement of Residents will receive restorative nursing care as needed to help promote optimal safety and independence.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on resident council meeting, clinical record review, observation, and resident and staff interviews, the facility failed to provide sufficient and competent staff to meet resident needs with bathroom cares and answering call lights timely for 1 of 10 group resident interview and 2 of 18 sampled residents (Resident #15, #13, #4, #31). The facility reported a census of 89 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had diagnoses of Lewy Body dementia, diabetes, and pruritis (itching). The MDS recorded the resident had a Brief Interview for Mental Status (BIMS) score of 4,which indicated severely impaired cognition. The MDS documented the resident required substantial to maximal assistance for toileting, dressing, and personal hygiene, and had incontinence. The Care Plan revised 3/6/24 revealed the resident had incontinence and at risk for impaired skin integrity and had rashes/irritations. The staff directives included provide peri-care immediately after incontinence episodes. Observations revealed the following: a. During continuous observation 4/10/24 at 6:42 AM to 7:15 AM, no certified nursing assistants (CNA) seen on the [NAME] hall. b. On 4/10/24 at 7:16 AM, Staff H, CNA, walked down the [NAME] Hall. At 7:19 AM, Staff H, CNA, walked down the [NAME] Hall going the opposite direction. The surveyor asked Staff H if she was the aide on the [NAME] hall. Staff H said yes and kept walking. At 7:20 AM, Staff H, CNA, and Staff I, certified medication aide (CMA) entered Resident #31's room, donned gloves, and stood Resident #31 by her recliner. Staff I ambulated the resident to the bathroom and said it's wet all over when she pulled the resident's pants and brief down. Staff H picked up a pad saturated with what smelled and appeared to be urine from the resident's recliner seat and placed the saturated pad into a plastic bag. The cushion on the recliner also had a large round wet area. At 7:25 AM, Staff H left the room. Staff I said let's take these (pajamas) off, they are soaked. Staff I removed the resident's socks, flannel pajama pants, and saturated brief. Multiple scratches were observed to the resident's bilateral legs and arms. Staff I asked resident if she had been itching her legs. Staff I reported the resident itches a lot. At 7:38 AM, Staff I provided incontinence cares, then ambulated with the resident back to the recliner. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a confidential family interview 4/9/24 at 9:00 AM, a family member reported the facility didn't have enough aides and residents had to wait at least 1/2 hour for assistance. The evening shift had been the most problematic for staffing. During meals, dietary staff lined up trays then plated several trays at a time, then took the trays to the resident rooms. Often times the food sat on the trays for 20 minutes before staff took the trays of food to the resident rooms. Staff working on the North and South Hall split up the [NAME] hall residents. Whenever residents residing on the [NAME] Hall needed help, staff would say it's not their side of the hall, and refused to answer or assist residents on the opposite side of the hall. On 4/11/24 at 9:00 AM, Staff I, CMA, reported she aimed to staff each shift with at least one CNA on each hall (ABC and NWS halls) during the day and evening shifts, and she tried to cover a shift whenever they had call ins. Sometimes the restorative aide, shower aide or scheduler got pulled and worked the floor in order to cover the staff call ins. Staff I reported whenever she followed the night shift, she had found residents incontinent. Staff I reported she didn't normally work the [NAME] Hall, but confirmed Resident #31 usually incontinent, and wet a lot. In an interview 4/11/24 at 10:45 AM, Staff J, CNA, reported the facility was very short staffed. Staff J reported often times the shower aide was pulled to work as a CNA and then the residents didn't get showers that day. Staff J stated she sometimes found residents incontinent when she did initial rounds on the residents following the night shift. She found a couple of residents saturated (wet) as if the resident had not been changed during the night. Staff J stated some staff don't want to wake residents up and won't check and change the residents. She found those residents wet when she made rounds. On 4/11/24 at 11:45 AM, Staff K, CNA reported staffing not very good at the facility. The facility only staffed one CNA on each hall. Staff K reported the residents on the South Hall often times needed the assistance of two staff. Staff K stated staff not able to get to call lights timely when they had less staff. Residents who normally are not incontinent ended up being incontinent because they had to wait for someone to take them to the bathroom. Staff K stated a number of resident falls when they are understaffed. Residents don't get showers because the shower aid worked the floor as a CNA due to staffing shortages. In an interview 4/11/24 at 12:45 PM, the Director of Nursing (DON) reported the facility determined staffing needs based on PPD (per patient days). The DON reported the bare minimum staffing would be at least three CNA's on the front (N/S/W halls) and three CNA's on the back (A/B/C halls). The DON reported it was tough when they worked with the minimum staffing level. Staff worked as a team to get things done. 48625 2. a. A Resident Council meeting conducted on 04/11/24 at 11:40 AM with approximately 10 residents in attendance. One of the residents in attendance commented that some Certified Nurse Assistant's (CNA) were not good at bathroom care and it depended on who provided care. The resident voiced the residents did not want to get anyone in trouble because the staff were nice people, but they weren't doing a good job. The resident commented he did not want to get an infection because someone else does not know how to do bathroom care the right way. The resident reported the concern occurred mostly on the 2-10 shift. The resident also voiced it always took forever for [NAME] Hallway to get a call light answered and CNAs would say they were on break when call lights aren't getting answered. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #15 identified a BIMS (Brief Interview for Mental Status) score of 15 which indicated intact cognition. c. On 4/8/24 at 03:15 PM Resident #15 reported it took a half hour for call lights to be answered. Resident #14 stated when the staff did enter to assist her with changing or cares they would shut off her light and leave to get someone to help them but never come back. Resident #15 voiced the staff would forget about her and the longest wait time she had to get changed was 2.5 hours. Resident #15 stated she knew if staff gone longer than 10 minutes she would need to turn her call light back on for help. The resident commented she felt awful when she had accidents. 49990 3. The Quarterly MDS dated [DATE] which revealed Resident #44's toileting status being dependent, as well as being fully incontinent of bowel and bladder. It also revealed diagnoses of peripheral artery disease and diabetes mellitus. Observation on 04/11/24 at 09:07 AM revealed R#44 in the hallway with visibly soiled clothes and wheel chair cushion. The residents pants were visibly wet down both legs, and smelled strongly of ammonia. In an interview on 04/11/24 at 09:11 AM Staff K stated they doesn't believe the facility has enough staff for them to do their job correctly. They stated resident toileting and personal cares are slow as a result. In an interview on 04/11/24 at 10:45 AM Staff U stated they don't have enough staff for them to do everything their job requires. 47582 4. An observation of room W 32 on 4/10/24 at 6:45 AM revealed Staff G, CNA, appeared to be sitting in a chair with eyes closed. The room was occupied by 2 current residents, both resting in bed. A subsequent observation of room W 32 on 4/10/24 at 7:10 AM revealed Staff G, CNA, was in the same position, sitting in a chair with her eyes closed. During a conversion with the Administrator on 04/10/24 at 07:12 AM, after observing Staff G, CNA sitting in the W 32 room, she reported that it was a visitor. The following day, on 4/11/24 at 2:40 PM the Administrator reported it was in fact a staff member, Staff G, CNA, who was in room W32 sitting in a chair and she was no longer employed at the facility after the incident. She stated her expectations of staff was not to be sleeping at work.

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	165162	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48625 Based on clinical record review, resident interview, and staff interview, the facility failed to ensure a resident who desired to receive routine dental care for a cleaning and to assess for possible oral cavities received arrangement of services for 1 of 1 residents reviewed for dental services (Resident #15). The facility reported a census of 89 residents. Findings include: The Quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #15 identified a BIMS (Brief Interview for Mental Status) score of 15 which indicated intact cognition. The Significant Change MDS dated [DATE] recorded under the dental section the resident with obvious or likely cavity or broken natural teeth. The Progress Notes dated 9/1/2023 and 12/26/2023 indicated the resident requested dental services with no follow-up documentation contained in progress notes. On initial interview 04/08/24 at 4:10 PM Resident #15 stated she had been on the list to go to the dentist for months. On 04/09/24 at 03:09 PM staff in charge of dental scheduling (Staff T, Certified Medication Aide), indicated Resident #15 refused dental care. Staff T provided an undated document stating resident refused dental care. In a subsequent interview on 04/10/24 at 9:07 AM Resident #15 stated she had not seen a dentist since admission. Resident #15 described that she might have some cavities and rated her mouth pain as a 2 out of 10 (on a scale of zero to ten with ten being the worst pain). Resident #15 reported she had requested several times to see the dentist. At 09:28 AM Resident # 15 stated she was willing to leave the room and described that she was willing to use the mechanical lift, use her wheelchair, and leave the room for dental care. Resident #15 stated she had never been offered dental care and did not refuse dental care. On 4/10/24 at 10:13 AM Social Services Director reported Resident #15 refused dental care in the past as she did not want to leave the room. The Social Services Director later provided information from the Account Manager indicating Resident #15's mother did not sign the application for dental care. The Progress Notes contain no mention of follow up with Resident #15, no alternative treatment, or other mention of dental care services being provided for the resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49990 Based on observation, staff interview, facility policy review, and facility maintenance records, the facility failed to maintain the combination walk-in freezer and refrigerator in a clean and satisfactory condition. The facility reported a census of 89. Findings include: Observation on 04/08/24 at 1:15 PM revealed frost in the freezer had recently melted, formed an icicle, and dripped on an open box of chicken. The icicle that hung in the corner was approximately six inches in length at the time of the initial observation. On 04/11/24 at 09:02 AM Staff R, Dietary Supervisor stated they have been aware of the frost and drip issue for the duration of their employment, about one year. They noted it is the responsibility of kitchen staff and the dietary supervisors to report issues with the freezer to the maintenance supervisor. They reported staff have been instructed not to place items under the areas of the freezer where the dripping occurs. On 04/11/24 at 09:05 AM Staff P, Maintenance Supervisor reported he was not made aware of the frost and drip issue. He notes there had been no service to the freezer in the five months since he was employed by the facility. He did not know when the freezer was last inspected. On 04/11/24 at 10:49 AM Staff Q, Dietary Supervisor stated the frost and drip issue has been around for at least five years based on other staff observations. They noted they are instructed not to store things under the dripping area but have been due to a lack of space in the freezer. Maintenance log review showed the refrigerator and freezer combo had last been serviced on 01/20/23 by the [NAME] Group. The maintenance consisted of the replacement of a new fan blade and fan motor for the walking refrigerator portion of the unit. An undated policy titled Refrigerators and Freezers stated Supervisors will inspect refrigerators and freezers monthly for gasket condition, fan condition, presence of rust, excess condensation, and any other damage or maintenance needs. Necessary repairs will be initiated immediately.

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	165162	A. Building B. Wing	04/11/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, observation, staff interview, and facility policy review, facility staff failed to follow infection control practices in order to prevent and control the onset and spread of infection within the facility by not removing soiled gloves and performing hand hygiene for two of two nursing units observed. The facility also failed to disinfect resident care devices when soiled with urine and failed to ensure staff utilized infection control techniques in order to prevent cross contamination for 3 of 4 residents observed during incontinence cares (Resident #2, #31, and #47). The facility reported a census of 89 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had diagnoses of Lewy Body dementia, diabetes, and pruritis (itching). The MDS recorded the resident had a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition. The MDS documented the resident required substantial to maximal assistance for toileting, dressing, and personal hygiene, and had incontinence. The Care Plan revised 3/6/24 revealed the resident had incontinence and at risk for impaired skin integrity and had rashes/irritations. The staff directives included provide peri-care immediately after incontinence episodes. During observation on 4/10/24 at 7:20 AM, Staff H, Certified Nursing Assistant (CNA), and Staff I, Certified Medication Aide (CMA), donned gloves and assisted Resident #31 to stand by a recliner. Staff I walked with the resident to the bathroom and reported it's wet all over and the pajamas soaked as she removed the resident's pajamas and brief. Staff I removed the resident's socks, flannel PJ pants, and saturated brief. Staff H picked up a pad saturated with what smelled and appeared to be urine from the resident's recliner seat and placed the saturated pad into a plastic bag. The cushion on the recliner also had a large round wet area. At 7:25 AM, Staff H opened the door with her gloved hand, took the plastic bag to a lidded cart in the [NAME] hallway, removed one glove, then lifted the lid and placed the bag inside. Staff H did not return to Resident #31's room. At 7:43 AM, Staff I assisted the resident to change clothes and provided incontinence cares. Staff I then ambulated the resident back to the recliner. The resident sat down on the cushion in the recliner. Staff did not disinfect the cushion in the recliner. On 4/11/24 at 12:45 PM, the Director of Nursing (DON) reported she expected gloves changed anytime staff touched something dirty and before touched something clean. The DON reported she expected staff used hand sanitizer or washed hands in-between glove changes. A Personal Protective Equipment - Using Gloves policy revised 9/2010 revealed gloves removed and discarded into the waste receptacle inside the room. Hands washed after gloves removed. Gloves don't replace handwashing. A Cleaning and Disinfection of Resident Care Items and Equipment policy revised 9/2022 revealed resident care equipment including durable medical equipment cleaned and disinfected according to current CDC (Center for Diseases) recommendations for disinfection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Center for Diseases website https://www.cdc.gov/infectioncontrol/guidelines/disinfection/recommendations. html revealed disinfection in healthcare facilities recommendations included the need to ensure noncritical patient-care devices disinfected whenever visibly soiled. 33878 2. a. Observation on 04/10/24 at 11:24 AM revealed Staff G, Certified Nurse Aide (CNA), and Staff D, CNA, entered Resident #47's room to conduct a transfer with a mechanical lift and incontinence care. Without performing hand hygiene, Staff G and Staff D assisted the resident to transfer to the bed with the mechanical lift. Staff D donned gloves and set a pair of gloves and a clean incontinence brief on the end of the bed. Without washing or sanitizing hands, Staff G donned the gloves which Staff D set on the end of the bed. Staff G un-tabbed the soiled incontinence pad, grabbed wet wipes to provide incontinence care, and wiped the front perineal area down the center front to back. Staff G failed to cleanse all areas of the residents body which came into contact with the soiled brief. Staff G transferred the used wipe from one hand to the other, then inserted both contaminated gloved hands into the incontinence wipe package to obtain new wipes. Staff G continued to perform incontinence care on the resident's backside wiping the buttocks front to back up the center of the buttocks only. Observation revealed a slight yellowish-brownish substance on the wet wipes. Staff G removed gloves. Without performing hand hygiene or donning new gloves, Staff G opened the clean brief and tucked it under the resident touching bare buttock. Staff G touched her gait belt with both hands to readjust it around her neck. Staff G then assisted to tab the new brief with the same ungloved, contaminated hands. Staff G and Staff D worked to roll the resident back and forth to pull up the residents pants and place a transfer sling. Staff G continued to connect the transfer sling loops to the transfer machine touching the transfer bar, machine handles, and the remote control. Staff G remade the bed while Staff D removed his gloves but failed to perform hand hygiene after removal. In an interview at the end of provision of cares, Staff G commented when Staff D told her to put on gloves, put on gloves, she was annoyed as she knew what she was doing and when she needed to put on gloves. Staff G then reported she needed to move the mechanical lift back to where it goes. Staff G transported the machine to the end of the hallway and placed it outside of room B52. Staff G failed to sanitize the mechanical lift where her contaminated hands had touched. Staff G then assisted a resident in a wheelchair to the dining room placing her contaminated hands on the wheelchair handle bars. Staff G never performed hand hygiene. b. Observation on 04/11/24 at 08:12 AM revealed Staff T, Certified Medication Aide (CMA), assisted residents in the dining room with meal set up going from table to table providing set up assist and delivering trays. Staff T did not perform hand hygiene prior to grabbing Resident #2's built up silverware spoon when the resident attempted to take a bite. Staff T tapped the contents of the spoon off on a bowl then used pressure against the plate to adjust the position of the spoon. Staff T then set down the spoon and grabbed the resident's fork. Staff T moved the plates and cups then went to the steam table to take food to another resident. Staff T continued in this manner without performing hand hygiene in-between residents when touching their silverware. The facility policy titled Handwashing / Hand Hygiene revised August 2019 included the following documentation: (continued on next page)

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	165162	A. Building B. Wing	04/11/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Point 2 - All personnel shall follow the handwashing / hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Point 7 - Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents h. Before moving from a contaminated body site to a clean body site during resident care i. After contact with a resident's intact skin k. After handling used dressings, contaminated equipment, etc. m. After removing gloves p. Before and after assisting a resident with meals Point 9 - The use of gloves does not replace hand washing / hand Hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33878 Based on CDC (Center for Disease Control) recommendations, clinical record review, and staff interview, the facility failed to provide education and administration of pneumococcal immunization for 28 residents identified by the facility eligible to be offered and 2 of 5 residents reviewed for pneumonia vaccine (Resident #18, #47). The facility reported a census of 89 residents. Findings include: The CDC website, https://www.cdc.gov/vaccines/vpd/pneumo/, published 9/21/23 recorded the CDC recommended PCV15 or PCV20 for adults who never received a PCV and are ages [AGE] years or older. For ages 19 through [AGE] years old with certain risk conditions, if PCV15 was used, it should be followed by a dose of PPSV23. The CDC recommended adults who received an earlier PCV (PCV7 or PCV13) should talk with a vaccine provider. The provider can explain available options to complete the pneumococcal vaccine series. Adults [AGE] years or older have the option to get PCV20 if they have already received PCV13 (but not PCV15 or PCV20) at any age and PPSV23 at or after the age of [AGE] years old. These adults can talk with a vaccine provider and decide, together, whether to get PCV20. The clinical EHR (Electronic Health Record) recorded the age for Resident #18 as [AGE] years old. The immunization tab of the EHR contained historical documentation of the pneumovax 23 on 1/1/1999. The clinical record lack documentation the resident consented, refused, or received the vaccine Prevnar 20. The clinical EHR recorded the age of Resident #47 as [AGE] years old. The immunization tab of the EHR lacked documentation of Prevnar 20 administration. The progress notes dated 11/7/23 at 4:26 PM for Resident #47 recorded the POA (Power of Attorney) consented for the resident to receive the pneumonia vaccine. The clinical record for Resident #47 lacked documentation of the pneumonia vaccine administration. An email dated 4/1/24 from the corporate Director of Infection Prevention and Staff Development documented a list of residents were audited for Prevnar 20 Pneumococcal Vaccine administration who were eligible to be offered and administered the vaccine. The email recorded some on the list were offered other forms of pneumonia vaccine and refused but the list indicated the facility did not have documentation they had been offered the newest version. The email documented 28 residents were identified that unless they had been offered and refused 20, and it was not documented, they would be 100% eligible. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/24 at 3:55 PM the Infection Preventionist / Director of Nursing (DON) reported they recently conducted an audit for completion of Prevnar 20 pneumococcal vaccination. The undated Performance Improvement Plan (PIP) documented the biggest difference the plan would make would be that all residents who consented would be up to date on Prevnar 20 pneumococcal vaccine and would have it administered within 14 days. The PIP recorded a target date of 4/1/24. The PIP list of residents included: Resident #18 and documented as Eligible, offer PN20 Resident #47 and documented as Eligible, offer PN20