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	02/27/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46513 Based on observation, interviews and policy review, the facility failed to ensure residents' dignity demonstrated by lack of dressing assistance prior to a meal in the main dining room and disregard to privacy for 2 of 6 residents reviewed for dignity (Residents #84, #89). The facility reported a census of 94 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment for Resident #89 dated 2/11/254 documented diagnosis included non-traumatic spinal cord dysfunction and paraplegia. The MDS revealed the resident had required substantial or maximal assistance with upper and lower body dressing. The Brief Interview for Mental Status (BIMS) exam scored 15 out of 15 which indicated intact cognition. The Care Plan focus initiated 1/23/25 for Resident #89 documented, self-care deficit as evidenced by requiring assistance with activities of daily living included dressing. Intervention under category of dressing and undressing, directed one-person assistance. The mobility category documented, does not ambulate, utilizes wheelchair that staff propels. An observation on 2/24/25 at 12:44 PM Resident #89 sitting in the main dining room eating lunch. Resident #89 wore a hospital gown with a blanket on his lap. The hospital gown was open revealing residents' skin on his back. In an interview on 2/24/25 at 12:45 Resident #89 relayed to the Administrator and surveyor when asked if wanted to get dressed prior to the meal, and if staff offered to assist with dressing. Resident #89 responded the staff were too busy and acknowledged staff had not offered to assist with dressing today. On 2/24/25 The Administrator acknowledged a dignity concern related to Resident #89 not having assistance with change of clothing and coming to the dining room not dressed appropriately. Facility policy titled, Dignity revised February 2021 documented, each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times, #5a directed when assisting with care, encourage to dress in clothing that they prefer. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49990 2. The Quarterly MDS for Resident #84, dated 01/28/2025, documented his brief interview for mental status (BIMS) score as 15, which indicated intact cognition. It documented the following diagnoses: Heart failure, Hypertension, renal insufficiency, and revealed the resident had a urinary tract infection no more than 30 days before the MDS was finished. It further documented the resident was dependent upon staff for toileting transfers, toileting and personal hygiene, as well as lower body dressing. The Care Plan for Resident #84, last revised 02/03/2025, documented the resident required two-person assistance for toileting and toileting hygiene. It also documented the resident had impaired vision due to glaucoma and macular degeneration. The Quarterly MDS for Resident #74, dated 12/12/2024, documented the residents BIMS score as 13, indicating intact cognition. It further documented Resident #74 was dependent on staff for all transfers and ambulation. In a direct observation on 02/26/2025 at 11:20 AM, Staff E (CNA), and Staff F (CNA), were providing toileting assistance for Resident #84 at his request. During the observation Staff E and Staff F used a mechanical lift to assist Resident #84 to the rest room, and due to the constrains on the size of the bathroom and the equipment they were unable to close the bathroom door. They pulled the resident's hospital style gown up, without closing the privacy curtain for his roommate (Resident #74), exposing Resident #84's genital area to his roommate. In an interview on 02/27/2025 at 09:30 AM with Resident #74, he stated staff members never pull the curtain when assisting his roommate with toileting. He stated it bothers him, and that he should not have to see it. He stated it bothers him.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on observations, staff interviews, and policy review, the facility failed to provide a comfortable and homelike environment. The facility identified a census of 94 residents. Findings include: 1. Observations revealed the following: a. On 2/24/25 at 1:45 PM, a loud beeping sound audible in the hallway and in a resident's room with the door closed. b. On 2/24/25 at 1:47 PM, Hall A and B had an odor that smelled like urine. A large gray barrel had the lid partially off and garbage inside. Hall C had four wheelchairs, a linen cart, a weight chair, a Broda chair, a mechanical lift and carts with lids lined along the hallway. c. On 2/24/25 at 1:55 PM, a loud beeping sound continued in the ABC hall. d. On 2/24/25 at 2:09 PM, the loud beeping sound continued. e. On 2/24/25 at 2:32 PM, the loud beeping sound subsided. f. On 2/24/25 at 3:02 PM, Hall C had three wheelchairs, a broda chair, a weight chair, a linen cart, a mechanical lift, and a soiled linen cart parked along the handrail in the hallway. g. On 2/24/25 at 3:19 PM, a male resident in a wheelchair sat in Hall A and another male resident in a motorized wheelchair came down the same hall going in the opposite direction in the same hall. Hall A had five wheelchairs, a mechanical lift, two 3-drawer bins with PPE (personal protective equipment) inside, a linen cart, a soiled linen and trash cart with lids were parked along the hall and blocking the handrail so the resident in the wheelchair was unable to use the handrail and maneuver himself down the hall. Staff M, Licensed Practical Nurse (LPN), came and assisted the male resident in the wheelchair in order for the resident in the motorized wheelchair to get by. Resident #12 kept pointing at a wheelchair that was in her way in the hallway because she was not able to propel herself in the wheelchair due to the equipment in the hall. h. On 2/24/25 at 3:30 PM, the [NAME] hall had a high pitched beeping sound. i. On 2/25/25 at 8:00 AM, the ABC hall had a constant high-pitched beeping sound. A light panel at the nurse's station had an A lit up in red and a C lit up in white. Hall A had five wheelchairs, one 4-wheeled walker, two 3-drawer bins with PPE inside, a linen cart, a weight chair, a mechanical lift, and a treatment cart parked along the even numbered side of Hall A. Hall C had a mechanical lift, a wheelchair, a weight chair, a black chair, a soiled linen and trash cart with lids, and a clean linen cart parked along the odd numbered side of the hall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	j. On 2/25/25 at 8:15 AM, the panel at the nurse's station continued to have a constant high-pitched beeping sound. The red and white lights labeled C were lit up on the panel. The beeping sound was audible in Halls A, B, and C. At 8:25 AM, the constant high-pitched beeping sound continued at the nurse's station panel. The red and white lights labeled C were lit up on the panel. At 8:40 AM, the constant high-pitched beeping sound continued at the nurse's station panel. At 8:53 AM, the high-pitched beeping sound continued at the nurse's station panel. At 8:57 AM, the beeping sound stopped and no call lights were on in Halls A, B or C. h. On 2/25/25 at 10:52 AM, the [NAME] Hall's soiled linen cart was full and had two bags of soiled linen propping the lid open on the cart. i. On 2/25/25 at 12:53 PM, Hall A had a linen cart, a trash and soiled linen cart, a mechanical lift, four wheelchairs, one 4-wheeled walked, two 3-drawer bins with PPE inside parked in the hallway on the side with even numbered rooms. At the time, a large air mattress was lying on the floor in the hallway. j. On 2/26/25 at 10:54 AM, a gray barrel with lid was parked in the hallway outside room A33. Resident #39 sat in a motorized wheelchair and drove himself down Hall A toward the dining room. The resident stopped the motorized wheelchair and moved the barrel to the handrail then pushed the barrel with the footrests on the wheelchair until he could get past the objects in the hallway. In an interview 2/26/25 at 7:36 AM, Staff K, Housekeeper, reported she cleaned Halls B and C, and sometimes cleaned Hall A when another housekeeper not working the area. Staff K reported the equipment was always parked in the hallway. Staff K confirmed she had observed residents having a hard time getting through the halls due to the amount of equipment kept in it. On 2/26/25 at 3:25 PM in an interview with Staff L, Assistant Director of Nursing (ADON), a continuous beeping sound was heard. The surveyor asked Staff L what the sound was. Staff L reported the beeping sound was a call light. At that time, another alarm sounded. Staff L identified the alarm as a door alarm and then went to check it. Staff L came back and said she could tell the various sounds based on the sound and how loud the sound or the alarm was. Staff L reported the facility used to have call lights that just lit up in the hall by the resident rooms but one day maintenance did something so the call lights would sound/beep. Staff L reported a resident also wandered and set off the exit door alarm. The loud sounds and alarms constantly went off during the day. Staff L thought the alarms and beeping sounds made residents more antsy and the residents had increased behaviors. Staff L reported the loud sounds /alarms were constant all day long. She agreed the lack of sleep could make people more on edge and have less tolerance. Staff L acknowledged they stored lots of equipment in the hallways because they had no storage room for the equipment. She asked staff to fold up the wheelchairs kept in the hallway to give people more room to get through the area. Staff had to move over and stop in the hallway in order to let a resident or others pass by. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview 2/27/25 at 10:20 AM, Resident #35 reported the door alarms went off at least eight times during the day. Resident #35 reported the alarm sounded whenever another resident or someone went out the exit door. The alarm also went off at night. Resident #35 reported she just had to get used to the alarms going off but acknowledged it was hard to get much sleep. A Quality of Life-Homelike Environment policy revised 5/2017 revealed a safe, clean, comfortable and homelike environment provided to the residents. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting, including comfortable noise levels, an orderly environment, and clean bed linens in good condition. 46513 2. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] Resident #54 included primary diagnoses debility cardiorespiratory condition, additional diagnoses, stroke, anxiety, depression and documented need for assistance with personal care. Resident coded independent with dressing and personal hygiene, is frequently incontinent. Resident #54 had not attempted to walk ten feet due to medical condition or safety concerns, independently transferred wheel chair to bed and toilet. The Brief Interview for Mental Status (BIMS) exam scored 15 out of 15 indicated intact cognition. The Care Plan intervention initiated 4/5/23 relayed Resident #54 had a self-care deficit as evidenced by requiring assistance with activities of daily living (ADLs) impaired balance during transitions, required assistance, incontinence. During an observation on 02/24/25 at 1:33 PM Resident #54 lying on her bed, mattress was dark blue plastic like covering, no sheets or linens of any kind. The bed had strong odor of urine. During an observation on 2/25/25 at 3:00 PM Resident #54 lying on her bed no sheets on the plastic like material that covered mattress. During an observation on 2/26/25 at 3:05 PM Resident #54 lying on bed no covering on the mattress. On 2/26/25 at 3:05 PM Resident #54 relayed housekeeping came in today, had no concerns with that and Certified Nursing Assistant (CNA) staff are supposed to provide linens and they still have not done so or offered help. During an observation on 02/27/25 01:36 PM observed Resident #54 lying on the bed, no covering on the mattress. On 2/27/25 at 1:40 PM met with the Director of Nurses (DON) and the Administrator. The DON relayed Resident #54 has history of incontinence in bed, changed the mattress as a result, relayed linen changes are expected to be done on shower days and as needed, was not aware of concerns regarding resident bedding. The Administrator and DON did not know why resident #54 would not have sheets on the mattress. The DON relayed would visit with Resident #54. On 02/27/25 at 1:46 PM Resident #54 in room, DON visited with Resident #54 who voiced is a little weak. DON queried about the bedding. Resident #54 relayed staff would take care of bedding, did not know when. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an interview on 2/26/24 at 8:40, Registered Nurse (RN) Staff D queried regarding the strong odor of urine odor in the [NAME] hall. RN, Staff D relayed containers of dirty linen and trash is usual and would be taken to another room when the containers were full. Observation on 2/26/25 at 8:40 AM revealed two covered containers of trash and soiled linens about half full. A strong pungent odor throughout the entire west hall. 49990 3. A direct observation on 02/25/2025 at 08:28 AM revealed a loud repetitive alarm sounding in Halls A, B, and C. It sounded from at least the time of initial observation until 08:41 AM when the alarm finally ended. Facility staff identified the alarm as the call light alarm. A direct observation on 02/25/2025 at 09:04 PM revealed The [NAME] Hall room light alarm currently sounding. The alarm could be heard in all six hallways of the building clearly. In an interview on 02/25/2025 at 09:15 PM with Staff W, Registered Nurse (RN), she noted the facility is always this loud. She reported it is sometimes so noisy she has trouble thinking. In an interview on 02/25/2025 at 09:19 PM with Resident #84 he demanded to know what the commotion was outside. He did not notice it was the surveyor stated he just saw someone walking by and wanted to know what was going on. He stated the facility has been extremely loud, with an alarm sounding continuously for some time and what sounded like a party in the hallway. The sounds of the party were identified as the television in the ABC hall dining room, which was currently airing a television show at max volume. The surveyor confirmed the television could be heard clearly down halls A, B, and C. A direct observation of the ABC halls on 02/25/2025 at 09:19 PM revealed an alarm sounding in the C hallway that could be heard clearly in all three hallways. It sounded from 09:19 PM until 09:32 PM when it ended. A direct observation on 02/25/2025 at 09:36 PM revealed an alarm in the North/South/West portion of the building beginning to sound. It could be heard clearing in the A hallway. It sounded until 09:48 PM. A direct observation on 02/25/2025 at 10:23 PM revealed an alarm sounding in the North/South/West portion of the building. It can be clearly heard in all halls. It sounded until 10:37 PM. A direct observation on 02/25/2025 at 10:42 PM revealed the television in the A/B/C portion of the building had finally been turned off and was no longer making sound. In an interview on 02/27/2025 at 09:30 AM with Resident #74, he reported the building is always too loud. It makes it hard to sleep. Alarms go off all day and night. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/27/2025 at 12:06 PM with Staff E, Certified Nurses Aide (CNA) , she noted the facility is always loud. She stated residents have complained to her about trouble sleeping because of the constant loud alarms sounding in the building. She stated it drives her crazy listening to the constant drone of the alarms and loud TVs. She stated she does not feel the residents get any peace and quiet, even at night. In an interview on 02/27/2024 at 12:37 PM with the Director of Nursing (DON), she agreed the building was too loud, and noted the A/B/C halls were the loudest. She stated the volume of the alarm system increased after a recent change to the A/B/C hall alarm system.

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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. 49990 Based on record review, resident interview, and staff interview, the facility failed to provide rehabilitative services as ordered for 1 of 24 residents reviewed (Resident #84). The facility reported a census of 94. Findings include: The Quarterly MDS for Resident #84, dated 01/28/2025, documented his brief interview for mental status (BIMS) score as 15, indicating intact cognition. It documented the following diagnoses: Heart failure, Hypertension, renal insufficiency, Cerebrovascular Event (Stroke), Seizure disorder, Malnutrition, Acute respiratory failure, muscle weakness, and difficulty in walking. It further documented the resident was dependent upon staff for transferring, ambulation, and personal cares. The Care Plan for Resident #84, last revised 02/03/2025, documented PT/OT would evaluate and treat as ordered. It did not document a restorative plan. Speech Therapy (ST) Plan of Treatment with start of care date 1/29/25 documented Summary of Daily Skilled Services as follows; Physician's order received. Resident would benefit from further ST services in order to maintain cognitive abilities/progress and work toward discharge to least restrictive environment. Resident in agreement with plan of care and goals. Occupational Therapy Discharge Summary singed 2/13/25 documented recommendations as follows; restorative range of motion program. Physical Therapy Discharge Summary signed 2/13/25 documented recommendations of a restorative program to maintain gains made in therapy and prevent decline. During a review of physical therapy and occupational therapy (PT/OT) records, an order was found to start Resident #84 on restorative services with a start date of 02/13/2025. In an interview on 02/24/2025 at 12:41 PM with Resident #84, he stated he was not getting rehabilitative services. He stated he was told he was moving to a new program approximately two weeks prior to our arrival for survey but no one has spoken to him regarding the new program and the nurses and certified nurses' aides (CNAs) are unaware of what he is talking about. He stated he wants to get stronger so he has a chance of going home, but doesn't feel they are helping him. In an email from the Administrator on 02/26/2025 at 03:51 PM the Administrator stated the facility had no record the facility had been provided with the order from PT/OT services. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/27/2025 at 08:50 AM with the Director of Rehabilitative services, she shared with the surveyors a list of names who had been transitioned to Restorative services. She stated the system by which they provide the order to the Director of Nursing had recently changed, and while previously she signed a sheet documenting the receipt of the restorative order the facility no longer used the same sheets. She documented the date the order had been provided to the facility as 02/13/2025. In an interview on 02/27/2025 at 09:04 AM with the Director of Nursing, she confirmed the facility had recently changed the process by which the receipt of restorative orders was confirmed. She stated she could not find the order to transfer Resident #84 to restorative services in her inbox and confirmed Resident #84 had not received any rehabilitative or restorative services since 02/13/2025. She stated the facility was unaware of whom was at fault for the failure, and stated the facility planned on returning to the previous method by which restorative orders were confirmed to prevent future mistakes. Review of a facility provided policy titled Restorative Nursing Services, last revised in July 2017, states the following: Residents will receive restorative nursing care as needed to help promote optimal safety and independence.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49990 Based on direct observation, clinical record review, and Resident and staff interview, the facility failed to provide the residents the assistance needed in order to complete their individual activities of daily living for 4 of 4 residents reviewed (Residents #3, #12, #58, and #84). The facility reported a census of 94. Findings include: 1. The Quarterly MDS for Resident #84, dated 01/28/2025, documented his brief interview for mental status (BIMS) score as 15, indicating intact cognition. It documented the following diagnoses: Heart failure, Hypertension, renal insufficiency, Cerebrovascular Event (Stroke), Seizure disorder, Malnutrition, Acute respiratory failure, muscle weakness, and difficulty in walking. It further documented the resident was dependent upon staff for transferring, ambulation, and personal cares. The Care Plan for Resident #84, last revised 02/03/2025, documented the resident required an assist of one person for personal cares and encouragement for oral hygiene. It instructed staff members to check nail length and trim/clean on bath days and as needed. The Care Plan also documented the resident had impaired vision due to glaucoma and macular degeneration. In a direct observation on 02/24/2025 at 12:41 PM, Resident #84's fingernails were noted to be over an inch longer and visibly soiled with dark colored material. In the ensuring interview with Resident #84, he stated he had been requesting staff assisting him in cutting his fingernails for approximately a week. He stated he has trouble seeing his fingernails and can't see well enough to cut them due to his declining vision, but he knew his nails were too long because he had been cutting himself when he scratched. A review of shower/bath sheets documented Resident #84 had his nails last cut during a shower on 01/27/2025, however, this documentation is discrepant from the state of Resident #84's fingernails. Resident #84 stated his nails had not been cut since he admitted to the facility that he could remember; his admitted was noted as 11/28/2024. In an interview on 02/27/2025 at 12:06 PM with Staff E and Staff J (CNAs), they confirmed CNAs and Shower Aides are responsible for trimming nails during showers and as requested by the residents, they noted the only place to document nail care is the shower sheets. They stated they could not remember having cut Resident #84's fingernails recently. In an interview on 02/27/2025 at 12:30 PM with Staff A, Registered Nurse (RN), she confirmed CNAs and bathe aides document nail care on bath/shower sheets. She stated that CNAs are responsible for nail care unless a resident is diabetic, and she confirmed Resident #84 was not diabetic. In an interview on 02/27/2025 at 12:37 PM with the Director of Nursing (DON), she stated CNAs are responsible for trimming a resident's nails as needed and when requested. She confirmed the bathing/shower sheets are the only place to document the cares. She agreed the residents nails had not been trimmed in a considerable amount of time. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility provided document titled Activities of Daily Living (ADL), Supporting, with a last revised date in March of 2018, documented appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident in accordance with the plan of care, including appropriate support and assistance with hygiene. 34817 2. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had diagnoses of non-Alzheimer's dementia, diabetes and bipolar disorder. The MDS indicated the resident had impaired short-term and long-term memory and severely impaired daily decision making skills. The MDS indicated the resident required substantial to maximum assistance for bathing and had dependence on staff for personal hygiene. The Care Plan revised 12/5/24 revealed the resident required assistance with activities of daily living (ADL's). The Care Plan directed staff to provide assistance of one for bathing/showering, encourage bathing twice a week, trim and clean nails on bath days and as necessary and report any changes to the charge nurse. The Care Plan also revealed the resident needed set-up assistance for grooming and hygiene cares. The Care Plan directed staff to encourage cares in the morning, afternoon, and at bedtime, and reapproach and attempt ADL's at a later time if the resident became agitated or combative when staff tried to provide a shower or shaved her. The Pocket Care Plan revealed the resident required assistance of one staff for bathing. The Skin Monitoring: Comprehensive CNA (certified nursing assistant) Shower Review form reviewed 1/1/25 to 2/21/25 revealed the resident last had her face shaved on 1/29/25, last had her nails clipped on 1/29/25, and last had her hair washed on 2/5/25. Only 3 of 9 shower review forms documented 1/2025 and 3 of 6 shower review forms documented for 2/2025. The Task Care Record reviewed 2/1 - 2/25/25 revealed a shower/bath documented on 2/12/25. The Task Care Record lacked documentation about shaving, hair washed or nails clipped. The Progress Notes revealed staff documented the resident would not allow staff to clean and cut her nails on 12/29/24 at 3:23 PM and 2/25/25 at 3:35 PM. The progress notes lacked the resident refused a bath, hair washed, nails cut, or face shaved 2/1/25 - 2/24/25. The Shower Schedule for ABC on Hall C revealed Resident #12 scheduled for a shower on Wednesdays and Saturdays on the 6 AM - 2 PM shift. Observations revealed the following: a. On 2/24/25 at 3:20 PM, Resident #12 sat in a wheelchair in the hallway holding an empty glass in her hand. The resident had at least a 1/4 inch growth of facial hair to her chin and around her mouth. Her fingernails were long and a nail was broken. The resident had brown debris under her right thumb and her hair appeared greasy. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 2/25/25 at 2:40 PM, Resident #12 sat in a wheelchair in the hallway. The resident's had dried spillage on her striped pants and shirt from lunch. The resident continued to have white hair growth around her chin and mouth. At 4:45 PM, the resident continued to wear the striped pants and shirt with dried brownish-red spillage. The resident still had white hair growth around her chin and mouth. In an interview on 2/26/25 at 7:45 AM, Staff L, Assistant Director of Nursing (ADON), reported the resident's showers were documented in POC (Point of Care) as well as on paper. On 2/26/25 at 10:20 AM, the Director of Nursing (DON) reported she found some more shower sheets in Staff L's office. The DON provided the additional paper shower sheets to the surveyor to review. In an interview on 2/27/25 at 10:10 AM, Staff L, ADON, reported she expected staff provided the residents a shower as scheduled. The staff filled out a paper shower sheet whenever the resident had a shower. Staff L reported staff marked off if the resident's hair was washed and if the nails were clipped. She expected staff to document if the resident refused a bath and tell the nurse. Staff L stated she expected all residents, including female residents, got shaved twice a week, typically when they had their shower. In an interview 2/27/25 at 10:21 AM, Staff G, CNA, reported the shower schedule listed the resident rooms for each hall and the shift assigned to give the resident a shower. Staff G stated they also had to fill out a (paper) CNA shower sheet whenever a shower completed. The shower sheet had the resident's name on it. A shower also included washing the resident's hair and cutting the resident's nails. The category for nails trimmed was listed on that resident's shower sheet if a resident was supposed to get their nails cut by the CNA. If a resident refused a shower, she asked the resident again, and if the resident still refused a shower, she talked to the nurse. In an interview 2/27/25 at 12:00 PM, the Administrator reported no policy found for grooming or showers. A Supporting Activities of Daily Living policy revised 3/2018 revealed residents will be provided with the care and services to maintain their ability to carry out ADL's, including hygiene, bathing, and grooming. If cognitively impaired resident resisted care, staff will not assume the resident refused or declined care. Staff shall approach the resident in a different way or at a different time, or have another staff member speak with the resident as appropriate. 46513 3. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #58 revealed diagnoses included heart failure, seizure disorder, respiratory failure and bipolar disorder. Resident #58 required partial/moderate assistance with shower/bathing, transfers and sit to stand indicated a helper lifts holds or supports trunk or limbs, provides less than half of efforts. The MDS revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan dated 2/14/25 for Resident #58 relayed has self-care deficit as evidenced by requiring assistance with activities of daily living (ADLs) impaired balance during transitions required assistance walking. Interventions for bathing included one assist, encourage bathing twice a week, inspect skin during showers and alert the charge nurse of any skin issues. Noted history of refusing, prefers sponge bath, continue to reproach, educate, and encourage shower. The Electronic Record, look back to admit on 2/13/25 dated 2/25/25 revealed no showers given. One check mark to indicate on 2/15/25 Resident #58 refused The Progress Notes beginning at admit 2/13/25 did not document Resident #58 had refused bathing and did not document resident was approached, reproached, educated or encouraged to shower. On 2/24/25 at 10:00 AM Resident relayed not sure he had a shower and stated, they don't do much for you here. On 2/25/25 at 5:30 PM the Director of Nurses (DON) relayed showers should be documented in the electronic record and also on a paper record. Explained had a new staff that was supposed to audit this process who had been missing work. 4. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 revealed diagnoses included Spina Bifida, heart and respiratory failure, neurogenic bladder and seizure disorder. Resident #3 coded for dependent on assistance of two or more with toileting, dressing, personal hygiene and bathing. The MDS revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The Care Plan initiated 11/16/22 documented Resident #3 has self-care deficits evidenced by requiring assistance with activities of daily living. Interventions for bathing included two people assist, encourage bathing twice weekly, inspect skin and alert changes to the charge nurse. The Electronic Record, bathing/shower task beginning 10/28/24 to 2/25/25 displayed check marks indicated bathing activity. Documentation included: not applicable - (11) eleven times, Refused -(1) one time. Revealed (8)eight showers given in a (4) four-month period. Last shower prior to survey was 2/3/25 per the electronic record. On 2/24/25 at 1:08 PM Resident #3 relayed is supposed to have showers twice a week and there are many excuses from staff, relayed needs several staff to assist out of bed and this is very difficult. Resident #3 relayed it was a few weeks back since had a shower.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, observations, staff interviews, and policy review, the facility failed to ensure staff appropriately and safely transferred three of five residents observed during transfers (Resident #12, #19 and #84). The facility also failed to ensure cigarettes kept in a secure location for one of two residents reviewed for smoking (Resident#79). The facility also failed to reduce clutter in six of six hallways to create a homelike environment, and to ensure clear hallways for the residents to easily move throughout the facility without obstacles. The facility identified a census of 94 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had diagnoses of osteoporosis, dementia and bipolar disorder. The MDS documented the resident had 2 or more falls without injury. The MDS indicated the resident had impaired range of motion to bilateral lower extremities, and required substantial to maximum assistance for transfers. The Care Plan revised 12/5/24 revealed the resident had a risk for falls related poor safety awareness and impaired balance. The resident required a safe environment, utilized a wheelchair for mobility, and required the assistance of one for transfers. During observation on 2/25/25 at 9:01 AM, Staff H, certified nursing assistant (CNA) pushed Resident #12 in a wheelchair down Hall B to the small common area across from the ABC nurse's station without foot pedals. The resident's feet moved back and forth on the floor as the resident sat in the wheelchair and Staff H pushed the wheelchair. In an interview 2/26/25 at 3:25 PM, Staff L, Assistant Director of Nursing (ADON) reported she expected wheelchair pedals in place whenever staff pushed residents in a wheelchair. 2. The MDS assessment dated [DATE] revealed Resident #19 had diagnoses of arthritis, osteoporosis, and dementia. The MDS documented the resident required substantial to maximum assistance for transfers. The resident had two or more falls with injury and one fall with injury during the look-back period. The Care Plan revised 2/13/25 revealed Resident #19 had falls related to impaired balance and poor safety awareness. The Care Plan directed staff to cue, orient and supervise the resident, provide assistance of one staff for transfers, park the wheelchair next to the bed when resident in bed, apply brakes on the wheelchair, and ensure the resident wore the appropriate footwear whenever he utilized the wheelchair or ambulated. The Pocket Care Plan for Hall C updated 1/30/25 revealed Resident #19 required assistance of one for transfers. The Pocket Care Plan revealed in capital letters and black bold print: ALWAYS USE YOUR GAIT BELT. Observations revealed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 2/24/25 at 2:43 PM, Resident #19 lying in bed with his left leg hanging over the edge of the bed. The resident had a bruise on his left eye and a large purple hematoma and abrasion on the top left side of his head. No wheelchair was parked next to the bed. b. On 2/25/25 at 8:05 AM, the resident lying in bed on his back. The wheelchair was parked across the room. c. On 2/25/25 at 12:57 PM, Staff H, CNA, entered Resident #19's room and assisted the resident to the edge of the bed, then placed her arm under the resident's right arm and assisted the resident from the bed to a wheelchair. The resident held the arms on the wheelchair and was bent over the wheelchair. The resident was shaky and appeared unsteady during the transfer. The resident had socks on his feet but no shoes or gripper socks on. Staff H had a gait belt draped over her left shoulder and across her body but did not apply and use the gait belt when she transferred the resident. Staff H did not lock the brakes on the wheelchair before she transferred the resident. The wheelchair moved backward after the resident sat down in the wheelchair. At 1:01 PM, Staff H left the room. The call light string hung by the wall out of the resident's reach. In an interview on 2/25/25 at 4:51 PM, Staff L, ADON, reported she updated the Pocket Care Plans on the share drive. Pocket Care Plans kept in a folder at the nurse's station for each hall. Staff L confirmed the Pocket Care Plans updated on 2/20/25. She knows she updated the Pocket Care Plan for Hall C on the same date but she didn't change the date on the document. The date on the Pocket Care Plan for Hall C was 1/30/25 but it had current information and should be dated 2/20/25, because she updated Hall C's Pocket Care Plan when the Pocket Care Plans were updated for Hall A and Hall B. In an interview 2/26/25 at 3:25 PM, Staff L, ADON, reported she expected staff to use a gait belt whenever they transferred a resident who required assistance of one or two for transfers. She also expected staff lock the brakes on the wheelchair before a resident transferred. In an interview 2/27/25 at 10:21 AM, Staff G, CNA, reported she looked at the Point of Care (POC) and the paper pocket care plan to know how a resident transferred. Staff G stated a gait belt always used for residents that required the assistance of one or two staff for transfers. A Fall Prevention Program updated 12/23/01 revealed a gait belt should be used for all non-Hoyer staff assisted transfers. 3. The Quarterly MDS assessment dated [DATE] revealed Resident #79 had diagnoses of non-Alzheimer's dementia, lack of coordination, and muscle weakness. The resident had a Brief Interview for Mental Status (BIMS) score of 7, which indicated severely impaired cognition. The Care Plan revised 3/27/24 revealed the resident had impaired thought processes as evidenced by short-term and long-term memory deficit and impaired decisions related to diagnoses of encephalopathy and dementia. The Care Plan revealed the resident preferred to smoke while at the facility. The goal included the resident will smoke with appropriate safety precautions in place. The Care Plan directed staff to observe the resident to make sure the smoking policy is being followed and to insure the safety of self/others, ensure the resident gave cigarettes to the nurse or family after smoking, and do not allow the resident to keep cigarettes or smoking materials in his room. Observations revealed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 2/25/25 at 2:19 PM, two cigarettes sat on top of a dresser in room [ROOM NUMBER]. One of the cigarettes had a burnt off end and over half of the cigarette was gone, and one cigarette had not been smoked. At the time, the resident sat on the bed in the room. Staff I, LPN, stood in the room and provided a treatment to the resident's roommate. At 2:22 PM, Staff I, LPN, bagged up the trash and left the room. At 2:30 PM, the cigarettes remained on top of the dresser in the resident's room. b. On 2/26/25 at 7:23 AM, Resident #79 sat in a wheelchair in the room. Two cigarettes sat on the nightstand by the resident's bed. During an interview on 2/27/25 at 10:21 AM, Staff G, CNA, reported the residents' cigarettes were kept in a locked area. She would let the nurse know if she found cigarettes in a resident's room. In an interview 2/27/25 at 8:45 AM, Staff L, ADON, reported resident cigarettes kept in a locked storage room by the nurse's station. The cigarette packs had the resident's name on it. Staff L reported different staff took the smokers outside at designated smoke times. Staff gave residents a cigarette and used a lighter to light the cigarettes. Resident #79's cigarette pack had a note on it to let staff know they needed to monitor the resident because he sometimes pocketed cigarettes. The Facility's Tobacco Policy revised 9/21/23 revealed the facility shall maintain safe resident cigarette use practices. All employees share in the responsibility of enforcing the policy. Any tobacco use or smoking related privileges and concerns shall be noted on the care plan. Cigarette materials for residents will be secured by the facility when not in use. 4. The Quarterly MDS assessment dated [DATE] revealed Resident #84 had diagnoses of anemia, atrial fibrillation (irregular heartbeat), cerebrovascular accident (CVA (stroke), muscle weakness, and seizure disorder. The MDS indicated the resident had dependence on staff for transfers. The Care Plan revised 12/19/24 revealed Resident #84 had impaired balance during transitions and required assistance with Activities of Daily Living (ADL's). The Care Plan directed staff to use an EZ stand and assistance of two for transfers. During observations on 2/26/25 at 11:38 AM, Staff F, CNA, and Staff G, CNA, placed a sling behind Resident #84 and attached the sling to a stand mechanical lift. Staff F raised the resident up in the stand mechanical lift. Resident #84 stated he felt kind of dizzy after the staff stood him up. Staff G took disposable wipes and cleansed the resident's buttocks area, then Staff F placed a clean brief on the resident. At 11:43 AM, Staff F and Staff G transferred the resident from the bathroom over to the bed. The strap on the stand mechanical lift moved on the left side and the resident yelled out, what was that? Staff lowered the resident onto the bed. Resident #84 said sarcastically I'm ok. I'll live, I think. Staff removed the sling from the lift, then moved the residents legs onto the bed. Staff L, ADON stood in the room and observed staff during the transfer. A Sit to Stand Lift Competency Checklist revealed the following procedural steps: a. Gather equipment. b. Check to ensure harness and loops are in good condition. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. On 2/25/25 at 12:53 PM, Hall A had a linen cart, a trash and soiled linen cart, a mechanical lift, four wheelchairs, one 4-wheeled walked, two 3-drawer bins with PPE inside parked in the hallway on the side with even numbered rooms. At the time, a large air mattress was lying on the floor in the hallway. f. On 2/26/25 at 10:54 AM, a gray barrel with lid was parked in the hallway outside room A33. Resident #39 sat in a motorized wheelchair and drove himself down Hall A toward the dining room. The resident stopped the motorized wheelchair and moved the barrel to the handrail then pushed the barrel with the footrests on the wheelchair until he could get past the objects in the hallway. In an interview 2/26/25 at 7:36 AM, Staff K, Housekeeper, reported she cleaned Halls B and C, and sometimes cleaned Hall A when another housekeeper not working the area. Staff K reported the equipment was always parked in the hallway. Staff K confirmed she had observed residents having a hard time getting through the halls due to the amount of equipment kept in it. On 2/26/25 at 3:25 PM in an interview with Staff L, ADON, acknowledged they stored lots of equipment in the hallways because they had no storage room for the equipment. She asked staff to fold up the wheelchairs kept in the hallway to give people more room to get through the area. Staff had to move over and stop in the hallway in order to let a resident or others pass by. A Quality of Life-Homelike Environment policy revised 5/2017 revealed a safe, clean, comfortable and homelike environment provided to the residents. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting, including an orderly environment. 46513 5. The Minimum Data Set (MDS) for Resident #36 dated 2/11/25 revealed resident scored 09 on a Brief Interview for Mental Status (BIMS) exam, indicated moderate cognitive impairment. The MDS revealed the resident had not attempted to walk at least ten feet due to medical condition, safety concerns and used a manual wheelchair. The medical diagnoses included heart disease, kidney disease, hepatitis, dementia, seizure disorder, intellectual disabilities and psychotic disorders. The Care plan completed 7/20/23 for Resident #36 revealed a focus of self-care deficit as evidenced by requiring assistance with activities of daily living, impaired balance during transitions requiring assistance. interventions under mobility documented Resident #36 utilizes wheelchair that he can self propel, staff assist as needed. On 02/24/25 at 12:21 PM observation of resident #36 leaving the dining room with Registered Nurse (RN) Staff A behind the wheel chair, Staff RN pushed the chair several feet to Resident room. Staff A stopped and when resident did move self in the wheel chair Staff A pushed Resident #36 to the room approximated 25 feet to the door way. On 2/24/25 at 12:39 PM RN Staff A relayed Resident #36 will often scream, help and will not stop screaming until is helped, Relayed did push Resident and did not know why he does not have foot pedals on the wheel chair, would check on this. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/24/25 at 12:56 PM The Director of Nurses (DON) relayed staff should encourage resident mobility in the wheel chair and would look into having pedals assessable. The administrator present acknowledged the risks when a resident is pushed in a wheelchair without foot pedals. 49990 A direct observation on 02/24/2025 at 03:51 PM revealed clutter throughout the facility halls, including mechanical lifts, medication carts, wheelchairs, shower chairs, and other supportive devices. During the observation the A hall became blocked by a medication cart while in use by a nurse, forcing residents to wait before passing through the hall. A direct observation on 02/25/2025 at 09:21 AM revealed Staff Z, Activities Director, pushing Resident #60 in her wheelchair without foot pedals, Resident #60's legs were kicking quickly in an attempt to avoid contact with the pavement while being pushed. A direct observation on 02/25/2025 at 09:36 AM Revealed the North hallway currently impassable as multiple residents attempted to pass through the hallway at the same time. A certified nurses aide intervened at 09:38 AM to provide passage through the hall. A direct observation on 02/26/2025 at 02:00 PM revealed two residents blocking the A hall. One was asleep in her wheelchair and one was positioned in such a way that it made passing through by foot difficult and with the use of a mobility aide impossible. From 02:00 PM until 02:32 PM the hallway remained impassable with three different CNAs seen squeezing through on foot without attempting to clear the blockage. At 02:23 PM a CNA finally intervened, ending the blockage by providing transportation for the sleeping resident into her bedroom. During an observation on 02/25/2025 at 10:56 PM Staff V (CNA), and Staff W (RN), approached the surveyor to report the state of the halls. Staff V noted the halls are extremely cluttered and he has reported this to facility leadership several times without resolution. He noted the halls are often impassable and make his job more difficult. Staff W noted that she agrees with Staff V and that she believes the halls are a hazard to residents. In an interview on 02/27/2025 at 12:06 PM with Staff E (CNA), and Staff F (CNA), they stated there were too many objects in the hallways. Staff E noted that it prevents her from doing her job. She noted she has seen residents, especially those with cognitive impairments, becoming agitated and upset with each other when they can't get through the hallways. Staff F noted the procedure for when a resident is sleeping in the hallway is to gently wake them up and ask them if they would like to take a nap in their bed or a chair, and to assist them out of the hallway. In an interview on 02/27/2025 at 12:37 PM with the Director of Nursing (DON), she noted the halls have been an issue in the past. She mentioned she believed there had been a performance improvement plan (PIP) for the halls. She acknowledged a resident should not have been allowed to sleep in the hallway and block the path. The residents should have been assisted to their destinations and the sleeping resident should have been provided with assistance to her bed or a chair to rest. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/27/2025 at 11:01 AM with the Facility Administrator, she acknowledged the objects blocking the hall was an issue during the last survey, where it was the target of a citation. She noted there had been a PIP to address the issue after the last annual survey but it was closed without resolution.

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Altoona Nursing and Rehabilitation Center	200 Seventh Avenue SW Altoona, IA 50009

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on clinical record review, observation, interviews and facility policy the facility failed to provide appropriate intervention with urinary catheter to minimize or prevent complications from the reoccurring urinary tract infections for 1 of 3 residents reviewed for urinary conditions (Residents #195). The facility reported a census of 94 residents. Findings include: The Admission Minimum Data Set (MDS) dated [DATE] for Resident #195 relayed resident had an indwelling catheter. Diagnoses included benign prostatic hyperplasia (enlarged prostate), renal insufficiency, septicemia and sepsis unspecified organism. The Care Plan for Resident #195 initiated 2/19/25 documented Resident #195 had the potential for infection related to a history of sepsis, pneumonia, and catheter. Resident #195 has a supra pubic catheter, Goal to be managed appropriately and not exhibit signs of infection. Intervention included to provided catheter care as per the facility policy. In an interview on 2/24/25 12:15 PM with Resident #195 responsible party relayed resident recently hospitalized for pneumonia and urinary tract infection. During an observation on 2/26/25 at 8:50 AM 06/03/24 Resident #195 was in the main dining room for breakfast. Certified Nursing Assistant (CNA) Staff B relayed would take resident back to room and pushed resident in his wheel chair. The catheter tubing dragged on the floor. Surveyor brought the catheter concern to Staff B attention who attempted to adjust the tubing and started to push the wheel chair again and the tubing still touched and dragged the floor. On 2/26/25 at 8:52 AM The Assistant Director of Nurses (ADON), Staff C summoned from nearby office. ADON, Staff C relayed the bag should be hung on the higher bar under the wheel chair and ensured the bag placed higher to lift tubing from the floor. On 2/26/25 at 5:21 the Administrator acknowledged risks of catheter tubing dragging on the floor included infection and sepsis. Facility policy titled Catheter Care, Urinary, revised August 2022 documented purpose to prevent urinary catheter associated complications including urinary tract infections, to be sure the catheter tubing and drainage bag are kept off the floor.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49698 Based on observation, document review, facility assessment, resident and staff interviews, the facility failed to provide sufficient nursing staff to meet the residents' needs safely, in a timely manner and that promotes each resident's rights, physical, mental, and psychosocial well-being. The facility reported a census of 94 residents. Findings include: Observation of breakfast dining on 2/25/25 revealed the following: 8:30 AM, twenty-four residents were sitting in one of the facility's two dining rooms, dietary staff noted to be plating resident's food from a steam table. 8:39 AM, twenty-one of twenty-four residents had been served, three residents sat at an assisted feeding table had not been served their breakfast. 8:42 AM, a Certified Nursing Assistant (CNA) entered the dining room and assisted one male resident with feeding. Staff A, Registered Nurse (RN) assisted the second male resident with feeding. 8:46 AM, the third male resident, sat with his eyes closed, had his food sitting in front of him and not eating. 8:47 AM, Staff L, Assistant Director of Nursing (ADON) entered the dining room, Staff A, RN, pointed at the third male resident, indicating to the ADON the third resident needing assistance. 8:48 AM, Staff A, RN, spoke with the third male resident, asking him about eating. He had an untouched plate of pancakes, scrambled eggs, and a bowl of hot cereal. 8:50 AM, another CNA entered the dining room, offered the third resident beverages to drink, then sat with the resident to assist with feeding. During a confidential resident interview on 2/24/25 at 12:41 PM, Resident stated when he pushes his call light it can take 45 minutes to 2 hours for nursing staff to respond. The Resident had been told by nursing staff that they ' re going to do something or that they're going to get an order for something, but then don't. The Resident feels there is very little follow through from nursing staff and that nurses hold grudges. Nursing staff will come into his room and turn the call light off without addressing his concerns or needs. Resident stated he required transfers with a mechanical lift and this is often done with one person instead of the required two. The Resident verbalized concern of retaliation from nursing staff. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon entrance of facility on 2/25/25 at 9:15 PM, Staff V, RN, informed surveyor they had come at an excellent time and was planning on quitting because the staffing ratios are insane, by 10:00 PM the only people in the facility's front unit will be her and two CNAs. That is only three people for approximately 46 residents and indicated the ratio will be similar in the facility's second unit, with one nurse and two CNAs for 48 residents. On 2/25/25 at 10:19 PM, a CNA was overheard telling the nurse she wanted out of this place and wants to be done here. The CNA went on to say she feels there are a lot of corners being cut causing the residents to suffer, residents reported they had not been offered showers this week and another resident hadn't been offered a shower in three weeks. The CNA continued by saying the residents don't feel heard and feels that residents are often overlooked because they don't have enough staff most of the time. During an interview on 2/25/25 at 10:56 PM, Staff V, CNA reported at night there are only four CNAs in the building, making it hard to respond to call lights. During an interview on 2/27/25 at 12:06 PM, Staff E, CNA, stated she feels they do not have enough people to do their job, it's hard some days. When DIAL (Department of Inspections, Appeals, and Licensing) is here there are more people but usually there are less. During an interview on 2/27/25 at 12:06 PM, Staff N, CNA, stated that usually they're short staffed and it makes it so hard to do the job. On 2/27/25 at 12:26 PM, Staff X, CNA, stated she felt they did not have enough staff to consistently do their jobs, that the lights and alarms go off for a long time, 30-40 minutes, and CNAs are struggling and just can't keep up. Review of Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Data Report (a staffing data report that identifies triggered staffing areas of concern) revealed, the facility was triggered for excessively low weekend staffing for July 1, 2024 - September 30, 2024. Review of Facility Assessment, updated on 7/22/24 indicated, on page 29, the staffing plan based on resident population and their needs for care and support the facility's approach to ensure sufficient staff to meet the needs of the residents includes six to eight CNAs scheduled to the unit during the day shift, bath aides work 4, ten hour days to accommodate the resident's bathing, meals, toileting, etc. Additionally one to two Restorative Aides overlaps from the first to the second shift to assist with meals, toileting and other cares. During the evening shift six to eight CNAs are scheduled on the units. The night shift has four CNAs scheduled on the units. Page 35 indicated staffing patterns per unit for a census of 95 residents, two CNAs per hall, total of 8 CNAs for 6:00 AM to 2:00 PM, 8 CNAs for 2:00 PM to 10:00 PM, and 4 CNAs 10:00 PM to 6:00 AM. Review of facility provided daily staffing schedules for the weekends of July 1, 2024 through September 30, 2024 revealed of the two units in the facility, 13 shifts from 6:00 AM to 2:00 PM had 3 or less CNAs available on each unit (less than 1-1.5 CNAs on each hall), 9 shifts from 2:00 PM to 10:00 PM had 3 or less CNAs available on each unit (less than 1-1.5 CNAs on each hall), and on one occurrence, from 10:00 PM to 6:00 AM a unit had 1 CNA (1 CNA for two halls). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility provided daily staffing schedule for the weekends of February 2025 (three weekends) revealed of the two units in the facility, 2 shifts from 6:00 AM to 2:00 PM had 3 or less CNAs available on each unit (less than 1-1.5 CNAs on each hall), 4 shifts from 2:00 PM to 10:00 PM had 3 or less CNAs available on each unit (less than 1-1.5 CNAs on each hall), and on one occurrence, from 10:00 PM to 6:00 AM a unit had 1 CNA (1 CNA for two halls). During an interview on 2/27/25 at 2:10 PM, Staff Y, Scheduling Coordinator, revealed when making the schedules for each unit it is expected to schedule 4-5 CNAs on each unit for the 6:00 AM to 2:00 PM and 2:00 PM to 10:00 PM shifts and 2 CNAs on each unit for the 10:00 PM to 6:00 AM shift. The schedules are made out this way but there are often call-ins and there have been CNAs who have no call no show for their shift. Staff Y, Scheduling Coordinator acknowledged there have been shifts where only 3 CNAs have been on each unit, which happened frequently and he did his best to find coverage for the CNAs that did not make their shift and had covered these shifts many times himself, as he is also a CNA.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 50500 Based on record review, staff interview, and facility contract the facility failed to effectively coordinate medication management with hospice services to assist with symptom management in relation to resident and Power of Attorney (POA) wishes for 1 of 1 residents reviewed for Hospice (Resident #73). The facility reported a census of 94. Findings include: The Significant Change Minimum Data Set (MDS) assessment, dated 1/14/25, revealed Resident #73 with a Brief Interview for Mental Status score of 14, which indicated intact cognition. Diagnoses include anxiety, depression, encephalopathy (disease in which brain function is affected by a medical condition), history of bariatric surgery, malnutrition, and Non-Alzheimer's dementia. The MDS noted a life expectancy of less than six months with Hospice Care initiated. High risk medications listed on the MDS include antipsychotics, antianxiety, antidepressants, anticonvulsant, diuretic, and opioids. The Care Plan, last review completed 1/20/25, listed Resident #73 as independent with bed mobility, eating, dressing, and mobility. Resident #73 noted as independent with walker for transfers and toileting. The Care Plan reflected Hospice Services for Resident #73. Interventions include observing for non-verbal signs/symptoms of pain and/or discomfort (facial grimacing, moaning or repetitive movements), hospice providing supplies related to resident's terminal diagnosis (medications, equipment), and notify Hospice for changes in medical condition. The Order Summary Report, dated 2/27/25, included the following medications: Acetaminophen (for pain), Dicyclomine (for irritable bowel syndrome), Lorazepam (for anxiety), Morphine (for pain), Seroquel (for anxiety), Venlanfaxine (for depression), and Zofran (for nausea). The Lorazepam and Morphine both ordered as scheduled medications and also for as needed (PRN) use. Upon further review, the order summary for Ativan (Lorazepam) reflected 14 order changes from 1/4/25-2/26/25. The Progress Note dated 1/15/25, completed by the rounding Advanced Practice Registered Nurse (ARNP), noted that Resident #73 is on hospice for worsening Major Depressive Disorder with anxiety and persistent complications of gastric bypass affecting digestion and chronic abdominal pain. Resident #73 and their daughter requested comfort and were advised of the risk vs benefits of increasing medications. Resident #73 and their daughter accepted the risk since choice is for comfort. The Treatment Administration Record (TAR) for the month of February, 2025 directed staff to monitor for significant side effects of antidepressant and antipsychotic medications. Side effects include agitation, decreased appetite, drowsiness, headache, muscle tremor, postural hypotension, sedation. The TAR indicated no significant side effects were documented. The facility's Electronic Health Record (EHR) lacked specific conversations and communication between facility staff and Hospice regarding the management of antipsychotic medication. The electronic health record lacked documentation of facility concerns or assessments regarding the management of antipsychotic medications by Hospice (signs/symptoms of resident being overmedicated). (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Hospice program Progress Notes revealed the following: a. On 2/13/25, Staff Q, Hospice RN, spoke with Staff O, APRN, regarding Resident #73's medications. Staff Q agreed with Staff O that the current regimen was effective for the resident's terminal agitation from the previous 2 weeks. Staff Q spoke with the facility Administrator as the Director of Nursing (DON) was not available. The Administrator voiced concerns that Resident #73 was overmedicated, specifically with Lorazepam and Seroquel. Staff Q explained Resident #73 appears to be transitioning. The Administrator voiced concern regarding Center for Medicare and Medicaid Services (CMS) regulations for the facility. When asked why, the Administrator stated the diagnosis is not correct for the indication to take Seroquel. Staff Q learned at this time that the facility ARNPs were no longer able to manage Resident #73's psychiatric medications. The facility had another provider for that. b. On 2/14/25: Staff R, Hospice RN, visited with the facility's DON where medication changes were discussed. Staff R voiced concern for potential terminal restlessness. The DON reported psych medication changes need to go through Staff P, ARNP with Metro Geriatric Psych. c. On 2/14/25, Staff R called the facility and spoke with Staff N, facility ARNP regarding Resident 73's behaviors and increased anxiety. Resident #73 replied No when asked if having any anxiety or pain. Staff N directed facility staff to administer a PRN dose of Morphine for suspected pain contributing to behaviors and comfort. Staff R noted that Resident #73 is not able to accurately report symptoms due to cognition. Staff R then spoke with the DON and Administrator. Staff R asked about PRN Lorazepam order. The DON reported it was discontinued by mistake and had been added back. d. On 2/15/25, Staff S, Hospice RN talked with the Assistant Director of Nursing working. Staff S noted that the PRN Lorazepam had only been administered on 2/14/25 at 3:00 PM and today at 2:20 PM. Staff S noted the facility had not provided a PRN dose of Lorazepam, as requested at approximately 9:30 AM, during Staff S's skilled visit at the facility earlier in the day e. On 2/19/25, Staff T, Hospice RN, received a call from the facility reporting Resident# 73 told the music therapist she wanted to kill herself. Staff T and the DON discussed resident's anxiety and medications. Staff T with multiple calls to Resident #73's daughter and facility. The daughter stated the facility Administrator sent a message (to the daughter) stating they would be happy to increase the Ativan but were waiting for hospice to call. f. On 2/22/25, Staff T received a call from the facility stating Resident #73 is anxious and agitated. Staff T contacted Metro Geriatric Psych and received an order for an increase with Lorazepam from the on-call provider. On 2/24/25, Staff T checked in with the facility Administrator and DON. Resident #73 was reported to be well-managed and no new concerns. Upon further discussion with facility staff, Resident #73 had been out of her room in a wheelchair. g. On 2/24/25, Staff T received a call from the DON and Staff P, APRN for psych service noting concerns of the Lorazepam increase over the weekend. Staff P provided new orders to decrease the Lorazepam. Staff T asked what happens if Resident #73 starts having behaviors. It was advised for hospice to contact a specific facility APRN first and then Staff P. If these two are not available, then contact the Hospice provider. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/25 at 11:30 AM, Staff T, Hospice R.N. acknowledged the frequent medication changes Resident #73 had experienced. Staff T noted Hospice staff had been collaborating with Staff O, facility APRN, regarding medication adjustments when Resident #73 admitted into Hospice. During an interview on 2/26/25 at 1:00 PM, the DON believed the Lorazepam changes were increased at larger doses than what was expected. Discussions were held with Hospice RN and facility APRN regarding medication management and not to adjust medications based on resident or family requests. On 2/13/25, the Hospice RN had a conversation with the facility Administrator regarding medication management. The Hospice RN believed Resident #73 with terminal restlessness and Lorazepam dosing was appropriate. The Administrator requested medication review but the Hospice RN did not believe it was needed. The Hospice Provider was contacted. A change in the covering Hospice RN was made (facility believed the previous RN was rude and not collaborating in cares). At this time, the facility elected to have antipsychotic medications ordered by Staff P, APRN from a psych service and not thru the facility APRNs. During an interview on 2/27/25 at 7:55 AM, Staff N explained each facility APRN will coordinate medication management with Hospice, based on unit division. This is done either via face-to-face or phone. Staff N reported facility administration informed them earlier this week that they will be overseeing antipsychotic medication management in collaboration with Staff P. Staff N was unsure why Hospice is not taking the lead as Hospice should be the one doing so. During an interview on 2/27/25 at 8:35 AM, Staff O, APRN explained collaborating with Hospice regarding medication management, including antipsychotics, since Resident #73 was admitted to Hospice. Staff O explained Lorazepam was initiated at .25ml PRN. Upon discussion with Hospice staff, this was increased to scheduled doses for comfort. Lorazepam was initiated .25ml every four hours. Staff O believed Resident #73 was still uncomfortable during this time based on reports from facility staff, family, and Hospice. Lorazepam was increased for a short time to .5ml every four hours. Staff O reported a few weeks ago, unable to remember exact date, they were informed not to adjust Resident #73's antipsychotic medications. Hospice would need to contact Staff P for changes. Staff O does not recall a rationale given for the change in medication management. Interview continued; Staff O continues to provide day to day medical management for Resident #73. Staff O does not believe Resident #73 was over sedated at any time and felt Hospice recommendations for medications were appropriate. Staff O acknowledged the number of falls Resident #73 had experienced this month. Staff O does not believe the antipsychotic medications are the only cause of falls. Resident #73 had not been eating or drinking, resulting in a significant weight loss and weakness. This lack of intake may also be contributing. Staff O notes that increased falls would be a risk for anyone receiving antipsychotic medications. During an interview on 2/27/25 at 9:45 AM, Staff U, Hospice Medical Director, aware of Resident #73 hospice admission and assessed their medical status as terminal. Staff U explained medications assist with comfort and doses may be escalated based on as needed usage along with proportionate dosing. Staff U believes the facility may be more guarded with antipsychotic management. Staff U reported approximately a week before last, the covering Hospice RN notified them of Resident #73's severe behaviors, including hallucinations. It was believed Resident #73 may be transitioning. Lorazepam was increased. Based on information received from Hospice RN, Staff U believes recommended antipsychotic medication changes were appropriate and reasonable. Staff U also suspects the facility's decrease in antipsychotic use was to decrease resident risk rather than maintaining resident comfort. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The contract signed between the facility and (name redacted)Hospice, dated 7/25/22, states Hospice shall furnish all care and services related to the Terminal Illness and associated conditions as identified in the Plan of Care in accordance with the following: a. Medical Direction and Patient Management. Hospice shall provide general medical direction to the Facility as necessary to manage and care out the Plan of Care for the Hospice Patient b. Coordination of Services. Hospice shall provide a RN who shall be responsible for the overall coordination of Hospice care with the Facility. c. Drugs and Pharmaceuticals. Hospice shall provide or arrange for the provision of all drugs and pharmaceuticals related to the management of the Terminal Illness which are specified in the Plan of Care.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 49698 Based on staff interview, review of CMS-2567 reports, and facility policy review, the facility failed to ensure an effective Quality Assurance Performance Improvement (QAPI) process to address previously identified quality deficiencies, resulting in multiple repeat deficiencies identified on the facility's current recertification survey. The facility reported a census of 94 residents. Findings include: Review of facility's CMS 2567 from a recertification and complaint surveys on 4/11/24, 2/13/24, 12/29/22, and 3/23/22 revealed the facility received non-harm level citations for infection prevention and control. The facility's Plan Of Correction (POC) for Recertification and Complaint Survey dated 4/11/24, revealed correction date of 5/2/24 for infection prevention and control revealed documentation present at the end of the CMS-2567 form included the following: The Facility reasonably ensures that infection control procedures are followed. This includes the proper usage of gloves for patients during perineal cares to prevent cross contamination. 1. Residents have been receiving proper cares 2. All residents who require assistance with personal cares and all residents who require isolation precautions could be affected. 3. All staff education was completed on 4/30/24 where proper glove usage and infection control practices were discussed. A CNA skills fair slot had been scheduled for May 9th, 14th and 16th 2024 where all CNAs are to have competency sign offs completed for ADL care, glove usage and infection control practices. The QAA committee reviewed this deficiency during its monthly meeting on 4/30/24. 4. The Director of Nursing or designee will complete weekly audits for 8 weeks to ensure that staff are using gloves appropriately and preventing cross contamination. The facility's POC for Complaint survey dated 2/13/24, revealed correction date of 3/11/24 for infection prevention and control revealed documentation present at the end of the CMS-2567 form included the following: The Facility reasonably ensures that infection control procedures are followed. This includes the proper usage of gloves for patients in isolation as well as during perineal cares. 1. Residents have been receiving proper perineal care and are no longer on isolation precautions. 2. All residents who require assistance with personal cares and all residents who require isolation precautions could be affected. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. An education was conducted with direct care staff on 3/5/24 regarding proper glove usage during perineal cares as well as when a patient is on isolation precautions. Facility peri care audits were initiated on 3/6/24. Gloves, hand hygiene, and cleansing are all specifically addressed in the audit. Educational posters regarding hand hygiene and infection control were placed in common areas around the facility on 3/8/24. 4. The Director of Nursing or designee will complete weekly audits for 8 weeks to ensure that staff are using gloves appropriately and completing hand hygiene as required. The facility's POC for Recertification and Complaint Survey dated 12/29/22, revealed correction date of 2/8/23 for infection prevention and control revealed documentation present at the end of the CMS-2567 form included the following: 1. All facility staff members were re-educated on appropriate Personal Protective Equipment (PPE) usage and compliance. 2. All staff will have completed the 4 educational videos per directed plan of correction by 2/8/23. PPE Lessons, Sparkling Surfaces, Clean Hands, Keep COVID OUT. 3. QA team participated in watching the Telligen Root Cause Analysis Training per directed plan of correction on 2/9/23. 4. QA team will monitor weekly for 4 weeks and then monthly for 3 months and ongoing for compliance. 5. PPE compliance audits will be completed 5 days a week x2 weeks. Weekly x4 weeks. Monthly x3 months and ongoing for compliance thereafter. Results will be forwarded to the QA/QAPI committee for review. The facility's POC for Recertification and Complaint Survey dated 3/23/22, revealed correction date of 4/14/22 for infection prevention and control revealed documentation present at the end of the CMS-2567 form included the following: The Facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 1. Staff will receive education regarding proper hand hygiene and glove use per facility policy and procedures. 2. Staff education regarding proper hand hygiene and glove use. 3. Audits will be completed weekly x2, twice weekly x2, monthly x2 and then randomly as needed. Results will be forwarded to the QA/QAPI Committee for review. 4. Responsible party: Infection Preventionist/DON/ADON (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's current Recertification Survey, entrance date 2/24/25, resulted in multiple repeated non-harm level deficient practices for the following areas: Safe/Clean/Comfortable/Homelike Environment, Activities of Daily Living (ADL), ADL Care Provided for Dependent Residents, Free of Accidents Hazards/Supervision/Devices, Sufficient Nursing Staff. On 02/27/25 at 4:24 PM, Facility Administrator revealed the Quality Assurance Committee meets monthly and continues to review concerns. Facility Administrator acknowledged repeat deficiencies and stated the facility created a RN Education position, this RN is responsible for continuing education to staff, providing audits and monitoring, providing orientation for new employees along with other responsibilities to assist and educate staff to maintain resident's safety and satisfaction as well as meeting regulations and compliance. Facility Administrator stated a RN had been hired for this position but is not currently able to meet the criteria of the position and will be looking for a replacement. The facility has also hired a new Environmental Manager and Laundry Manager and they have implemented new procedures. Review of facility provided Quality Assurance Performance Improvement (QAPI), updated 1/2/25 stated the following: The purpose of QAPI in our organization is to develop a culture of proactive leadership that solicits the input from employees in various departments, including contracted professionals, if indicated, as well as those we serve Residents, Resident Representatives, and family members. Further, our purpose includes ongoing development of plans for improvement leading to systematic changes that support exceptional health care to seniors and operating excellence in every aspect of our business. A. The facility Administrator will be responsible for leadership and coordination of QAPI plan. B. Corporate will provide leadership development opportunities regarding the QAPI process and facility wide education will be made available. C. The facility Administrator will monitor and ensure necessary resources (time, equipment, training, etc .) are available and will consult with the regional management team as needed to procure these resources. D. The Director of Nursing, or designee will be responsible for the development and ongoing monitoring of care giver proficiency. 1. Proficiency shall be determined during the orientation process using orientation checklists. 2. Ongoing proficiency shall be determined through the evaluation process and all other processes deemed necessary through the QAPI process.

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	02/27/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 record review, observations, staff interview, and policy review, the facility failed to utilize Enhanced Barrier Precautions (EBP's) and infection control practices for 1 of 4 residents sampled on EBP's (Resident #19). The facility also failed to ensure staff followed infection control practices to protect against cross contamination and potential spread of infection for a resident on droplet precautions for 1 of 4 residents on droplet/contact precautions. The facility reported a census of 94 residents. Findings include: The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had diagnoses diabetes, pneumonia and a Stage 3 pressure ulcer on the left heel. The MDS indicated the resident required substantial to maximum assistance for transfers. The Care Plan revised 12/31/24 revealed the resident had impaired skin integrity related to a Stage 3 pressure ulcer to the left heel and required EBP's. The resident also required assistance with Activities of Daily Living (ADL's). The Care Plan directed staff to implement EBP's during high contact care activities, provide treatments as ordered, and provide assistance of one for transfers. The Pocket Care Plan updated 1/30/25 revealed EBP's needed for Resident #19. A list of residents on EBP's hung on the Hall C shower room wall and had a note that gowns were mandatory. Resident #19's name was on the list. Observations revealed the following: a. On 2/24/25 at 2:43 PM, an EBP sign hung on the wall in the resident's room by the bed and dresser. The EBP sign revealed staff must wear a gown and gloves for high-contact care activities including wound care and transfers. b. On 2/25/25 at 2:22 PM, an EBP's sign hung on the wall by the dresser and on the wall by the doorway of the room. A 3-drawer bin sat by the door and had gowns and gloves inside. Staff I, Licensed Practical Nurse (LPN) sanitized her hands and placed wound care and dressing supplies on a barrier on top of the treatment cart. Staff I sanitized her hands, donned a pair of gloves, and removed the gripper sock on the resident's left foot. The left heel had an open area with some redness to the surrounding skin. Staff I changed her gloves and sanitized her hands, then cleansed the left heel wound with wound cleanser and gauze. Staff I changed her gloves, and placed betadine with gauze and an ABD dressing then applied a kerlix dressing over the left heel wound. Staff I removed her gloves and placed the bed in a lower position. Staff I wore an N95 mask and gloves during the procedure, but did not wear a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 2/26/25 at 3:25 PM, Staff L, Assistant Director of Nursing (ADON) reported Resident # 19 had a pressure sore on his left heel. An EBP sign placed by the resident's door and personal protective equipment such as gowns and gloves kept in the craft drawers by the door whenever a resident on EBP's. Staff L confirmed Resident #19 on EBP because he had a wound. Staff L stated she expected a gown and gloves worn by staff whenever staff performed resident cares such as a transfer or wound treatments. In an interview 2/27/25 at 3:02 PM, Staff H, certified nursing assistant, reported she did not understand what EBP's was. The facility's Enhanced Barrier Precautions policy dated 3/25/24 revealed EBP's are utilized to prevent the spread of multi-drug resistant organisms (MDRO's) to residents. Gowns and gloves worn during high-contact resident care activities such as transferring a resident and whenever wound care provided. Signs are posted indicating the resident required EBP's and personal protective equipment available for staff use.