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	03/19/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on record review, staff interview, the Long-Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1, and policy/guidance review the facility failed to ensure accuracy on residents' Comprehensive Minimum Data Set (MDS) assessments. Residents reviewed were coded incorrectly indicating their diagnoses were not determined to be a Preadmission Screening and Resident Review (PASRR) condition for 5 of 9 residents reviewed for MDS discrepancies (Residents #4, #7, #8, #53, and #54). The facility reported a census of 93 residents.Findings include:1. The MDS completed on 5/6/25, documented Resident #4's Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. The MDS included diagnoses of non-Alzheimer's dementia, anxiety disorder, depression, psychotic disorder, and schizophrenia. Section A1500 of Resident #4's MDS indicated resident is not currently considered by the state a level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Review of PASRR dated 6/29/23 indicated Resident #4 as level I positive with conditions of mental health disability and intellectual disability. Further review of the PASRR document stated Since this evaluation has determined that you have a PASRR condition, the facility will need to document your PASRR condition in important Medicaid nursing facility paperwork. The facility should mark yes for question A1500 on the Minimum Data Set, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?. Also, your specific PASRR condition(s) should be checked in question A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.2. The MDS completed on 5/6/25, documented Resident #7's BIMS score of 9, indicating moderate cognitive impairment. Diagnoses include anxiety disorder, depression, bipolar disorder, and post traumatic stress disorder. (PTSD). Section A1500 of Resident #7's MDS indicated resident is not currently considered by the state a level II PASRR process to have serious mental illness and/or intellectual disability or a related condition.Review of PASRR dated 6/5/23 indicated Resident #7 had a level I positive with conditions of mental health disability. Further review of the PASRR document stated Since this evaluation has determined that you have a PASRR condition, the facility will need to document your PASRR condition in important Medicaid nursing facility paperwork. The facility should mark yes for question A1500 on the Minimum Data Set, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?. Also, your specific PASRR condition(s) should be checked in question A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.3. The MDS completed on 5/6/25, documented Resident #8's BIMS score of 15, indicating cognitively intact. Diagnoses include cerebral palsy, anxiety disorder, depression, schizophrenia, and PTSD. Section A1500 of Resident #8's MDS indicated resident is not currently considered by the state a level II PASRR process to have serious mental illness and/or intellectual disability or a related condition.Review of PASRR dated 5/12/25 indicated Resident #8 as level I positive with conditions of mental health disability, intellectual disability (ID), and developmental disability/related condition (DD/RC). Further review of the PASRR document stated Since this evaluation has determined that you have a PASRR condition, the facility will need to document your PASRR condition in important Medicaid nursing facility paperwork. The (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility should mark yes for question A1500 on the Minimum Data Set, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? Also, your specific PASRR condition(s) should be checked in question A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.4. The MDS completed on 3/2/26, documented Resident #53's BIMS score of 99, indicating the resident was unable to complete the interview. Diagnoses include Non-Alzheimer's Dementia and bipolar disorder. Section A1500 of Resident #53's MDS indicated resident is not currently considered by the state a level II PASRR process to have serious mental illness and/or intellectual disability or a related condition.Review of PASRR dated 9/14/23 indicated Resident #53 as level I positive with conditions of mental health disability. Further review of the PASRR document stated Since this evaluation has determined that you have a PASRR condition, the facility will need to document your PASRR condition in important Medicaid nursing facility paperwork. The facility should mark yes for question A1500 on the Minimum Data Set, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?. Also, your specific PASRR condition(s) should be checked in question A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.5. The MDS completed on 5/30/25, documented Resident #54's BIMS score of 15, indicating cognitively intact. Diagnoses include anxiety disorder, depression, and bipolar disorder. Section A1500 of Resident #54's MDS indicated resident is not currently considered by the state a level II PASRR process to have serious mental illness and/or intellectual disability or a related condition.Review of PASRR dated 4/18/25 indicated Resident #54 as level II with approved special services for serious mental illness and diagnosis of bipolar disorder. Further review of the PASRR document stated Since this evaluation has determined that you have a PASRR condition, the facility will need to document your PASRR condition in important Medicaid nursing facility paperwork. The facility should mark yes for question A1500 on the Minimum Data Set, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?. Also, your specific PASRR condition(s) should be checked in question A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.During an interview on 3/19/26 at 12:18 PM Staff G, Corporate Offsite MDS Coordinator, stated the finalized MDS are submitted remotely. The facility's corporation had a Travel MDS Nurse go onsite to the facilities and complete the resident's in person assessments. The Travel MDS Nurse enters their assessments into the resident's electronic health record. Staff G, completes the other MDS areas with document review, like PASRRs, builds the MDS and finalizes the assessment. Staff G, reviewed noted documents, identified the PASSR documentation instructions for A1500, acknowledged the information didn't get completed correctly. Staff G verbalized they didn't have a complete understanding of the PASRRs and their documentation. Review of facility provided MDS 3.0 Completion Policy dated 2025 stated the following:Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan.1. Interdisciplinary Responsibility for Completion of MDS Sections:a. The responsibility of all sections of the MDS will be clearly assigned. b. Persons completing part of the assessment must attest to the accuracy of the section they completed by signature and indication of the relevant sections.c. The R.N. Coordinator signs, dates, and attests to timely completion of the RAI, once all other disciplines have completed their sections.The LTC Facility RAI 3.0 User's Manual Version 1.20.1 dated October 2025 directed to code 1, yes if PASRR level II screening determined the resident had a serious mental illness.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, resident interview, record review and policy, the facility failed to follow professional standards of medication administration for 1 of 4 resident's observed for medication administration (Resident #69). During an observation the staff left medication at bedside. The facility reported a census of 93.Findings include:Resident #69's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating a cognition intact. The MDS included diagnoses of diabetes, heart, lung, and kidney disease. Resident #69's March 2026 Medication Administration Record (MAR) included the following orders:a. Albuterol inhaler, inhale two puffs orally three times a dayb. Ipratropium bromide nasal solution, two sprays in both nostrils three times a day c. Fluticasone propionate nasal suspension two sprays in both nostrils two times a day On 3/18/26 at 12:24 PM, observed Resident #69 sitting at her bedside with her tray table in front of her. Observed a clear plastic bag with medications of two inhalers and a medicated nasal spray. Resident #69 reported the medication belonged to her and the staff left it for her.On 3/18/26 at 12:35 PM, Staff C, Certified Medication Aide (CMA), explained Resident #69 wanted her medications left with her. They usually try to sit with her until she takes all of her medications. She knew Resident #69 had the nose spray and inhalers at her bedside. Staff C confirmed Resident #69 didn't have orders to leave the medications at her bedside. Staff C explained they left them there because Resident #69 would scream if she didn't get her way. On 3/18/26 at 12:40 PM, Staff B, Licensed Practical Nurse (LPN), confirmed Resident #69 didn't have orders to keep medications at her bedside. She knew of confused residents in the hall including Resident #69's roommate. Staff B would ensure to remove the medications from the bedside and put in the locked medication cart.On 3/18/26 at 12:45 PM, the Assistant Director of Nursing (ADON) acknowledged Resident #69 didn't have an order to keep medications at her bedside. The ADON reported they would check on getting a physician's order so Resident #69 could administer their own meds if locked for safety. The facility policy titled, Resident Self-Administration of Medication dated 2025 documented consideration to appropriateness, safety, cognitive stats and ability, would include an assessment form and permitted only when it does not present a risk to confused residents. When determined bedside or in-room storage of medications would be a safety risk to other residents, the medications of residents permitted to self-administer are stored in the medication cart or medication room.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observations, clinical record review, staff interview, representative interview and facility policy review the facility failed to provide hand/nail hygiene for 3 of 3 days observed for one of 24 residents reviewed (Resident # 77). The facility reported a census of 93.Findings include: Resident #77's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 2, indicating severe cognitive impairments. The MDS included diagnoses of multiple sclerosis (an autoimmune disease where the immune system attacks the protective nerve covering, disrupting brain-body communication) and dementia.The Care Plan Focus initiated 7/12/24 documented Resident #77 had a self-care deficit and required assistance with activities of daily living (ADLs). The Interventions directed to provide nail care by checking, trimming, and cleaning nails during bath days and whenever needed.On 3/16/26 at 5:14 PM, Resident #77's Representative noted the cleanliness of Resident #77 could improve, specifically they requested better hand hygiene. An observation revealed brownish dark substance under Resident #77's nails.On 3/17/26 at 3:09 PM, observed Resident #77 sitting in a room looking outside, with a brownish, dark substance noted under fingernails.On 3/18/26 at 1:05 PM, witnessed Staff F, Certified Nurse Aide (CNA) take Resident #77 from the dining room in a wheel chair and placed in the common room in front of the television. Staff F failed to perform hand hygiene for Resident #77 after the meal. Resident #77 had dark, brownish material observed under their fingernails. On 3/18/26 at 1:24 PM, Staff E, CNA, and Staff F assisted Resident #77 to bed. They acknowledged Resident #77 depended on staff to help with their care. They acknowledged Resident #77's nails had a brownish dark substance underneath on both hands. When questioned about Resident #77's hygiene, including oral and hand hygiene, the CNAs responded that nail care is typically handled by the activities staff once a week or is performed during showers.On 3/18/26 1:31 PM, the Assistant Director of Nurses (ADON) reported the staff have access to a small tool to clean under nails. They thought what Resident #77 had under their nails was likely food since Resident #77 ate with their hands. The ADON added they would ensure someone trimmed and cleaned Resident #77's nails right away. A sign observed in Resident #77's room revealed, they liked to eat with their hands. The sign directed to please help them clean the wheel chair and themselves after each meal.A policy titled Nail Care dated 2025 instructed to provide routine cleaning and inspection of nails during care on an ongoing basis.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on electronic health record (EHR) review, staff interviews, and policy review, the facility failed to complete neurological checks for a resident with an unwitnessed fall for 1 of 2 residents reviewed for falls (Resident #98). The facility reported a census of 93. Findings include: The Minimum Data Set (MDS) Assessment completed 1/19/26 revealed Resident #98 had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS noted Resident #98 required substantial to maximum staff assistance for transfers and bed mobility. Resident #98 utilized a wheelchair for mobility. Diagnoses include anemia (low red cell blood count), diabetes, insomnia, and osteomyelitis (infection of the bone) to the amputation site of the right lower leg/foot. The Care Plan, initiated 1/15/26, indicated Resident #98 had a risk for falls due to impaired balance, recent AMputation, poor safety awareness, and impaired neuromuscular function (connection breakdown between nerves and muscles causing weakness, fatigue). The Care Plan indicated a fall on 1/17/26. The Progress Note dated 1/17/26 at 3:09 PM completed by the Advanced Practice Registered Nurse (ARNP), described Resident #98 as a poor historian due to cognitive/psychiatric impairment. They saw Resident #98 due to hallucinations, a fall, and a lack of intravenous (IV) access. During the visit, Resident #98 commented the ceiling was coming down and the lights slid down the wall. The ARNP decreased their pain medications. The Progress Note dated 1/17/26 at 7:06 PM documented nursing was notified at 12:30 PM as Resident #98 was on the floor. After assessing, the staff returned Resident #98 to bed using a mechanical lift. Resident #98 explained they tried to sit on the edge of the bed when they slid out and voiced they did not hit their head. The facility Incident Report noted no one witnessed Resident #98's fall. Resident #98 didn't go to the hospital. The EHR lacked documentation of neurological checks after the unwitnessed fall. During an interview on 3/19/26 at 8:45 AM, Staff H, Licensed Practical Nurse (LPN), confirmed they worked as the nurse on duty at the time of Resident #98's fall. Staff H stated Resident #98 appeared intact cogitatively but noted some acute confusion possibly related to an on-going infection. Staff H explained neurological checks were initiated and documented on paper, as per facility procedures. After their shift was over, Staff H informed the on-coming nurse of Resident #98's fall and passed on the neurological checks sheet for further assessments. During an interview on 3/19/26 at 12:24 PM, the Director of Nursing (DON) voiced they were under the impression that neurological checks were not indicated at this time. Since Resident #98 had a higher BIMS and voiced they did not hit their head, neurological checks did not need to be completed. The American Association of Post-Acute Care Nursing Post Fall Assessments released August 2021 defined a neurological check as an assessment of neurological status, often called a neuro check. A neuro check should be done when a resident hits their head or if it is unknown if they hit their head (unwitnessed fall). The section related to Follow-up Assessment and Monitoring indicated it is not always immediately obvious that a resident sustained a life threatening injury. Therefore, nurses must take great care to complete thorough follow-up assessments. The policy Assessing Falls and Their Causes, version 1.3, noted the following:If a resident fell or is found on the floor without a witness, evaluate for possible injuries to the head, neck, spine, and extremities;Observe for delayed complications of a fall for approximately 48-hours after an observed or suspected fall;Document observed signs or symptoms of pain, swelling, and any changes in level or responsiveness/consciousness. The undated policy Head Injury noted an assessment is completed following a known, suspected, or verbalized head injury. Neuro checks performed as indicated or as specified by the physician. Continue to monitor for 72-hours following the incident or until Resident #98 is asymptomatic for a period of time specified by the physician.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on electronic health record (EHR) review, staff interviews, and policy review, the facility failed to complete smoking assessments for 1 of 1 residents reviewed for smoking (Resident #4). The facility reported a census of 93. Findings include: The Minimum Data Set (MDS) Assessment completed 3/12/26 revealed Resident #4 with a Brief Interview for Mental Status score of 10, indicating impaired cognition. Diagnoses include non-Alzheimer's dementia, seizure disorder, and stroke. The Care Plan with a Target Date of 6/14/26 indicated Resident #4 smoked. Interventions included the completion of quarterly smoking assessments.The facilty acknowledged it is a smoking facility and provided a list of current residents who smoke. Resident #4's name was noted. Review of the EHR verified a smoking assessment was completed on 3/12/26. No further smoking assessments were identified that correlated with the resident's quarterly MDS (4/30/25, 7/28/25, 10/23/25, and 1/21/26). During an interview on 3/18/26, Staff I, Activities Assistant, confirmed Resident #4 went out to smoke during the designated smoke times. Staff I explained any smoking safety devices, like a smoking apron, are identified through smoking assessments completed by the nursing staff. When asked how often the assessments are completed, Staff I thought quarterly. During an interview on 3/19/26 at 12:20 PM, Staff G, corporate offsite MDS Coordinator, explained the finalized MDS is submitted remotely. The facility didn't have a specific staff member onsite to complete. Staff G added a corporate Travel MDS Nurse went to facilities and completed any required in-person assessments, like a smoking assessment. During an interview on 3/19/26 at 12:45 PM, the Director of Nursing (DON) explained smoking assessments are now completed by the corporate MDS Coordinator, which is a new process prior to this, smoking assessments were completed by the facility's unit managers quarterly. The DON reviewed Resident #4's EHR and acknowledged the lack of smoking assessments. The policy Tobacco Policy, updated 9/21/23, noted residents who wish to use tobacco/smoke will be evaluated for safe smoking upon admission and quarterly.