STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165367	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Care and Rehabilitation Center	501 South Kentucky Ave Mason City, IA 50401

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, resident interviews, and food temperatures during food services, the facility failed to serve food within the appropriate temperature ranges throughout the observed meal service. The interviewed residents reported the food temperature as not satisfactory. The facility identified a census of 61 residents.Findings include:On 8/13/25 from 11:30 AM to 1:20 PM, observed Staff L, Cook, and Staff N, Cook, serve the facility residents their meal. Prior to service of the meal, Staff L, took the temperature of the turkey burger, French fries, cauliflower, cauliflower soup, ground turkey, mashed potatoes, puree cauliflower, puree turkey burger, macaroni and cheese and oatmeal. Staff N took the temperature of the last tray. The temperatures measured as mashed potatoes 120 Fahrenheit (F), cauliflower 110 F, and the French fries 114 F. The facility failed to keep food at the correct holding temperature.In an interview on 8/11/25 at 11:29 AM Resident #4 reported he ate in his room and described the food as cold. He stated he had cold scrambled eggs. He explained the food only felt warm to the touch. In an interview on 8/11/25 at 11:47 AM Resident #46 said she ate in her room, and she sometimes got cold food. In an interview on 8/11/25 at 11:55 AM Resident #12 stated she didn't care for the food. She expressed the food sometimes came hot and sometimes not. Resident #12 stated she ate in her room. The Food Handling Policy dated October 2023 instructed all Temperature Controlled for Safety (TCS) foods must meet the following temperature requirements during storage, preparation, display, service, and transportation:Hot FoodsCook all products to required internal temperatureReheat foods rapidly to a minimum temperature of 165 F (74 Celsius (C)) for a minimum of 15 secondsHold foods at 135 F (57 C) or aboveInterview on 8/13/25 at 4:21 PM, the Dietary Manager (DM) reported she planned to request to get the steam table looked at and provide more education.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, resident interviews, and food temperatures during food services, the facility failed follow infection control practices while preparing the residents' meal. During the kitchen observation, the staff didn't remove their gloves after touching non-food items before touching food items while wearing the same gloves. The facility reported a census of 61 residents. Findings include:On 8/13/25 at 11:30 AM Staff L, Cook, completed hand hygiene, then applied gloves to the right hand. With their gloved hand, Staff L grabbed the hamburger bun sack and reached in to grab a bun, placed the bun on the plate, opened the bun, grabbed the tongs, and placed the turkey burger on the bottom bun. Without changing their gloves or completing hand hygiene, Staff L placed the top of the bun on the turkey burger with their gloved hands. Staff L repeated the process several times through the meal service. When asked to make a peanut butter sandwich, Staff L removed her soiled glove from her right hand, performed hand hygiene, and then applied new gloves to both hands. Staff L grabbed the bread sack from the drawer, untwisted the tie and grabbed 2 pieces of bread from the sack. Then Staff L grabbed 2 peanut butter packets with her gloved hands along with the knife and proceeded to spread peanut butter on the bread. Staff L grabbed the bread and put it together to make the sandwich and cut the sandwich with the knife. Staff L placed the sandwich on a plate with her soiled gloves. Afterwards Staff L, removed her gloves and washed her hands. On 8/13/25 at 12:30 PM observed Staff N, Cook, perform hand hygiene and apply gloves to both of her hands. Afterwards, Staff N reached into the hamburger bun bag, grab a hamburger bun, place it on the plate, opened the bun, grabbed the tongs with her gloved hand, placed the turkey burger on the bottom bun, then with her gloved hand placed the top bun on the turkey burger. Staff N grabbed a plate, a bowl, and used a ladle to put soup in the bowl. Staff N then grabbed a ham sandwich with her soiled gloved hands and placed it on the plate. Staff N repeated this process through the rest of the meal service. Per the undated facility Policy named Glove Use instructed to wear gloves to maintain safe and sanitary food preparation and service. In addition, the policy directed to use proper utensils for food handling. Gloves must be worn when having direct skin contact with food. Before handling ready to eat food such as salads, fruit, sandwiches, meats, breads, or ice, put gloves on as a barrier to the bacteria on hands. The policy reflected the proper use of gloves as the following:Wash hands thoroughly before and after wearing or changing gloves. Bacteria will build up under gloves and should be washed away after wearing gloves.Change gloves periodically to minimize the buildup of perspiration and bacteria.Change gloves whenever you change an activity, the type of food being worked with, or whenever you leave the workstation.Interview on 8/13/25 at 4:21 PM the Dietary Manager stated she expected them to separate the buns prior to serving so that way they can use the tongs to place the bottom bun on the plate and the product on the top bun. She added they would do education on the process of gloving.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to follow infection control practices during the observation of 3 residents and during the kitchen observation (Residents #7, #10, and #14). As Staff A, Licensed Practical Nurse (LPN), gave Resident #7 their medications, they failed to complete hand hygiene or apply new gloves after they tested their blood sugar. As Staff B, Certified Nurse Aide (CNA), Staff C (CNA), and Staff D, Minimum Data Set (MDS)/Care Plan Registered Nurse (RN), provided care to Resident #10, they all removed their glove/s after assisting with repositioning and/or cares, but failed to complete hand hygiene before applying new glove/s. In addition, Staff B didn't clean Resident #10's urinary catheter or their hips as they did perineal (peri) care. Staff D had to remind Staff B and Staff C to put on gowns, after they checked Resident #10's adult briefs without wearing gowns. As Staff G, LPN, provided treatment to Resident #14's pressure ulcer, she failed to follow Enhanced Barrier Precautions (EBP) as she didn't wear a gown. In addition, Staff G didn't complete hand hygiene after she cleaned Resident #14's wound and a bowel movement (BM) after she removed and applied new gloves. The facility reported a census of 61 residents. Findings include:1. Resident #7's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) a score of 14, indicating intact cognition. The MDS included diagnoses of diabetes and schizophrenia. Resident #7 received insulin injections for 7 out of 7 days during the lookback period. Resident #7's August 2025 Medication Administration Record (MAR) directed staff to: 7/31/25: Check blood glucose (BG blood sugar level) 4 times a day. If BG is less than 70, treat with 4 ounces of juice and recheck after 30 minutes. Contact provider if BG is less than 70 after treatment. Contact provider if BG is greater than 450. Documentation on 8/11/25 at lunch time listed a BG of 106 signed by Staff A. 10/16/24: Spray 2 sprays of saline nasal spray solution (saline spray) in both nostrils 3 times a day for dry sinus. Staff A documented on 8/11/25 at lunch time given to Resident #7. On 8/11/25 at 11:50 AM, Staff A brought in medications in a medication cup and put the glucometer on a paper towel barrier with an alcohol swab, a lancet, a strip, and a cotton ball. In addition, she sat down a normal saline nasal spray. Staff A administered Resident #7's oral medications. Staff A then applied gloves wiped Resident #7's finger off with the alcohol swab, fanned it dry with her hand, and poked Resident #7's finger with the lancet. She wiped the first blood drop off then put the second drop on the strip, and put the cotton ball on Resident #7's finger. Staff A removed her gloves after gathering and disposing of the supplies. Staff A failed to complete hand hygiene or put on new gloves. Staff A then grabbed the nasal spray and squirted 2 squirts into each of Resident #7's nostrils. Following the observation, Staff A acknowledged she forgot to put on gloves before administering the nasal spray. When asked if she should have sanitized her hands she responded yes, she should have done both. 2. Resident #10's MDS dated [DATE], identified the facility attempted to conduct a BIMS interview. The facility conducted a staff interview instead. The interview determined Resident #10 had short- and long-term memory loss, disorganized thinking and resident to be moderately impaired. Resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#10 required partial to moderate assistance for upper and lower body dressing, rolling left to right in bed, and toileting hygiene. The MDS included diagnoses congestive heart failure, encephalopathy (disease or disorder that can affect the brain) and inflammatory disorders of scrotum. The Care Plan Focuses with a target date of 9/24/25 indicated Resident #10 Used an indwelling catheter related to testicular edema (swelling). The goal listed Resident #10 would remain free of complications related to catheter use. The Interventions directed staff to provide catheter care. Needed EBP related to the use of a urinary catheter, wounds and diagnosis of outbreaks of herpes viral of genitalia and urogenital tract in isolation. The goal listed to minimize risk for transmission during high contact care activities. The interventions directed to assess for signs and symptoms of infection. On 8/11/25 at 12:20 PM, observed Staff B and Staff C respond to Resident #10's call light. They walked into his room. Noted a set of EBP drawers outside of Resident #10's room that contained a face shield, gowns, gloves, and sanitizing cloths. The door had a stop sign. Staff B and Staff C walked into his room. Resident #10 wanted repositioned, Staff B and Staff C wore gloves. As they went to reposition him, they raised his bed, undid his adult brief and stated they needed to change his adult brief. As they pulled his pillows from under his knees, Staff D came into the room, left the room, then returned to the room wearing a gown and gloves. Staff D softly directed Staff B and Staff C to put on gowns. Staff C stepped out of the room to get the gowns. Both Staff B and Staff C put on gowns. Resident #10 said he had to pee. Staff D told Resident #10 to remember he had a catheter in and the catheter can make him feel like he had to pee. Observed Resident #10 had both legs wrapped from the knee down to his feet in a disposable dressing. Staff D picked up Resident #10's heels when he voiced worry about his heels after the staff told him they were going to roll him on to his side. Staff B removed her gloves after performing peri care and cleaning BM off of Resident #10. Staff B didn't clean the catheter tubing nor did she wash Resident #10's hips. Staff C assisted Staff B by holding on to Resident #10 while turned on his side and then repositioned him back on to his back. Staff B removed her gloves then asked Staff D to get her new ones. Staff D removed one glove and took out 2 new gloves then handed those to Staff B, then grabbed another glove and donned it on to her non-gloved hand. Staff D failed to complete hand hygiene after removing her glove and putting on the new one. Staff C removed her gloves after turning Resident #10 then put new ones on. All 3 staff removed their gloves and put on new ones without completing hand hygiene. Staff D assisted again by holding onto his dressing covered legs during repositioning back on to his back. Directly following the observation, Staff C confirmed the nurse told them to put on gowns. Staff C stated she planned to do it to anyways. When asked if they should have put them on prior to pulling Resident #10's adult brief down, Staff C replied yes, they should have put gowns on before that. Staff C stated that sometimes the resident accidentally puts his call light on, so they walked in to check if that's what he did. Staff C stated because of that they didn't have on gowns on right away, but then when they decided to check him, they should have put on their gowns. On 8/11/25 at 1:00 PM, Staff D acknowledged they didn't clean Resident #10's catheter or hips. In addition, Staff D acknowledged they didn't remove their dirty gloves without completing hand hygiene before putting on new gloves. Staff D stated she had hand sanitizer in her pocket, and she knew right away, she should have sanitized her hand. Staff D acknowledged she lifted up Residents' legs and she should have sanitized her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #14's MDS assessment dated [DATE], identified a BIMS score of 15, indicating intact cognition. The MDS included diagnoses of non-Alzheimer's dementia, multiple sclerosis (MS) and irritable bowel syndrome. Resident #14 had a Stage 3 pressure ulcer. A Doctor's Order dated 7/31/25, directed staff to clean Resident #14's pressure ulcer on the coccyx with Vashe (wound cleaner), apply zinc-based barrier to peri (around) wound/edge. Apply collagen powder to wound bed and area undermining (wound continues to grow under the skin and is more difficult to determine the size), pack with calcium alginate (special wound dressing). Cover with silicone super absorbent. The order directed staff to do the treatment one time a day for skin healing and as needed. The Care Plan Focus with a target date of 10/29/25 indicated Resident #14 required EBP related to a urinary catheter and wounds. The goal listed to minimize risk for transmission during high contact care activities. The Interventions directed the following: EBP Precautions: Staff to wear a gown and gloves while performing high-contact care activities (high contact care activities to include performing wound care) Educate resident and/or responsible party on EBP Precautions On 8/13/25 at 11:30 AM, watched Staff G, LPN, lay supplies out on a tray table with a barrier underneath them. She washed her hands and applied gloves. Staff G didn't put on a gown. The Director of Nursing (DON) observed in the room and assisted to turn Resident #14 to her side because she had her wound on her coccyx (tailbone). Due to the wound and the use of an indwelling catheter, Resident #14 required EBP. Staff G removed the wound dressing and threw it away. Staff G cleansed the wound using Vashe wound wash, then cleaned around the wound. Staff G noted Resident #14 had a smear of BM. She cleaned the BM with 4 wipes, threw the wipes away, took her gloves off and threw them away. Staff G put on new gloves and filled the ulcer with collagen powder, applied Calmoseptine around the wound edge, put calcium alginate into the wound, then covered it with a dressing. Directly after the treatment, when asked if Staff G should have completed hand hygiene after removing her dirty gloves and putting on new ones, Staff G and the DON answered yes and acknowledged she should have completed hand hygiene after cleaning the wound and the BM. On 8/13/25 at 1:32 PM, the Administrator and DON acknowledged that in all observed instances above staff should have sanitized their hands between dirty and clean glove changes, they should have cleaned the catheter tubing during peri care, and they didn't follow EBP. The Enhanced Barrier Precautions policy dated March 2024, directed to use EBP in conjunction with standard precautions for residents with (if/when Contact Precaution requirements are not in place) wounds and/or indwelling medical devices (even if the resident is not known to be infected or colonized with a targeted MDRO).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, resident, and staff interviews, the facility failed to carry out therapy recommendations and provide restorative exercises for 1 of 1 resident reviewed for limited range of motion (Resident #40). The facility reported a census of 61 residents.Findings include:Resident #40's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 7, indicating moderately impaired cognition. The MDS listed Resident #40 as dependent on staff for toileting hygiene, bathing, and lower body dressing. She required partial to moderate assistance for upper body dressing. Resident #40 had limited Range of Motion (ROM) on one side of her upper and lower extremities. The MDS included diagnoses of hip fracture, aftercare following joint replacement surgery, abnormal posture, limitation of activities due to disability, difficulty walking, unsteadiness on feet and weakness.The Care Plan Focus with a target date of 10/6/25 indicated Resident #40's restorative schedule directed to provide active and passive ROM as well as exercises 4 times per week as tolerated. The Goal listed to improve or maintain current ROM within the next review.Resident #40's July 2025 Documentation Survey Report reflected a restorative program for active ROM to the lower extremities 4 times a week included documentation of 10, N on 7/16/25 and 7/23/25, and 15, N on 7/31/25. The question for the task identified Y meant yes, N meant no regarding the question did the resident refuse to participate in the restorative program. The form lacked documentation on the other days in the month.In an interview on 8/11/25 at 11:38 AM Resident #40 states she is supposed to get therapy to her left leg but doesn't usually get it.In an interview on 8/12/25 at 12:50 PM Staff E, Restorative Aide, stated Resident #40 had a restorative program 3-4 times a week. Staff E expressed Resident #40 wanted more, so she recommended Music in Motion. Staff E reported they did all of the documentation on restorative program in the electronic health record (EHR). She denied Resident #40 left the facility or refused restorative care. Staff E explained the facility only had her as the only person doing restorative and she did it 4 times a week. Staff E denied charting the resident's performance or refusals anywhere else. When questioned about why Resident #40 only had 5 documented sessions for the last 30 days, Staff E, responded she didn't know for sure. Staff E reported Resident #40 didn't have set days for their restorative program as her hours varied. Staff E reported Resident #40 received the current program on 6/26/25.In an interview on 8/13/25 at 8:09 AM with the Director of Nursing (DON) and the Corporate Nurse, The Corporate Nurse stated Occupational Therapy (OT) or Physical Therapy (PT) gave the Unit Managers their recommendations who gave a copy to the restorative aide. The DON stated she expected the staff complete whatever therapy they recommended or they documented the resident's refusal in the clinical record. She added they should tell the nurse refusals so they could be documented.In an interview on 8/13/25 at 12:15 PM Staff H, Physical Therapy Assistant (PTA), reported if a resident only received a restorative program 3 times in a months' time, it would not be an effective program.In an interview on 8/13/25 at 4:16 PM Staff I, PTA Supervisor, stated if a resident only received their restorative program 3 times in a months' time, it wouldn't be an effective program.In an interview on 8/13/25 at 4:34 PM Staff J, PTA, Stated if they performed the restorative program only performed 3 times in one month, it wouldn't be an effective program.A Restorative Program Process policy updated May 2025 defined the purpose as to improve or maintain function in physical abilities, activities of daily living, and prevent further impairment. The policy directed to attempt restorative practice be practiced for a total of at least 15 minutes over a 24-hour time period. In addition, it indicated the Care Plan should include goals, interventions, special instructions, and frequency of the restorative program.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide additional pharmacological and/or nonpharmacological pain management interventions. The facility only administered his routine pain medications for 1 of 1 resident reviewed (Resident #11). Resident #11 consistently reported his pain level at a 6 or 7 and the facility failed to provide additional interventions. The facility reported a census of 61 residents. Findings include: Resident #11's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of cerebrovascular accident (CVA), fusion of spine, low back pain and repeated falls. The MDS documented Resident #11 experienced pain almost constantly over the previous 5 days. The pain occasionally effected his sleep over the past 5 days. A Care Plan Focus with a target date of 9/10/25 indicated Resident #11 had complaints of pain described as chronic (long-term) - fusion of the spine. The Foal indicated Resident #11 stated he tolerable level of pain at a 5 or had relief with interventions. The Interventions directed the following:a. Administer pain medication per physician orders.b. Encourage/assist to reposition frequently to position of comfort.c. Evaluate efficacy of pain management.d. Evaluate pain level as ordered.e. Monitor for factors / activities that precipitate or aggravate pain.f. Non-Pharmacological Interventionsi) Coloringii) Deep Breathing Exercisesiii) Encourage socialization or time alone when needediv) Environmental modification factors- decrease noise, decrease stimulation, lighting, temperaturev) Family Visitsvi) Going for a walk or stroll outside when nicevii) Meditationviii) Music Therapyix) Offer a snackx) Offer blanket or comfort objectxi) Offer to lay down and restxii) Offer toileting or anticipating the needs of the residentxiii) Phone Callxiv) Physical Activity wheeling self in wheelchairxv) Structured daily routinexvi) Talk therapy and ask about life events or interestxvii) Watching Birdsxviii) Watching tvxix) Word puzzles, reading, games, prayer, and activitiesg. Notify medical provider (MD) if the medication provided inadequate pain relief as indicated.h. Notify the physician of unsuccessful interventions or if current complaint is a significant change from my past experience of pain.i. Observe for non-verbal signs of pain.j. Refer to therapy as needed.k. Staff to observe any behavior changes in usual routine, sleep patterns, decrease in functional abilities, decrease range of motion (ROM), withdrawal or resistance to care.l. Resident #11 received opioid (strong addictive pain medicine) medications.a. Will remain free of complications related to use of opioid medication i. Monitor for side effects such as: feelings of euphoria, dry mouth, headache, flushing, mental fog, constipation, drowsiness, itching, respiratory depression, lethargy, addiction, irregular heartbeat, depression, severe abdominal pain. ii. Monitor for symptoms of overdose such as: small, constricted pinpoint pupils, falling asleep or loss of consciousness, slow shallow breathing, choking or gurgling sounds, limp body, pale, blue or cold skin On 8/11/25 at 12:51 PM, Resident #11 stated he had pain ever since his stroke and then back surgery. He stated he used to receive 10 milligrams (mg) of pain medication, but they will only give him 5 mg now. Resident #11 said the facility gave him Tylenol but that didn't do shit. Resident #11 said the staff knew he had pain. Resident #11 didn't know why the facility couldn't give him more. Resident #11 rated his pain at a 7 or an 8 on a scale from 0-10 (0 being no pain and 10 being the worse pain). He described the pain went down his left leg. Resident #11 gave permission to look into the concern.On 8/12/25 at 12:32 PM, observed Resident #11 in his room sitting in a wheelchair, he rated his pain level at a 7 or 8. He stated at night he had pain at a 10 and he hardly could sleep.Resident #11's August 2025 Medication Administration Record (MAR) viewed on 8/13/25 documented the following:6/10/25 Acetaminophen 8-Hour Oral Tablet Extended Release 650 MG (Tylenol). Give 1 tablet by mouth 3 times a day for pain with a start date of 6/10/25. The documentation reflected Resident #11's pain level at the time of administration. The documentation up to 8/13/25 reflected pain levels of 6 or 7, with the exception of a 0 on the evening dose on 8/12/25.6/24/25: Oxycodone Oral Tablet 5 MG (opioid). Give 1 tablet by mouth every 6 hours for pain control. The documentation up (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to 8/13/25 reflected pain levels of 6 or 7, with the exception of a 0 on the evening dose on 8/12/25.6/10/25: Acetaminophen 8 Hour Oral Tablet Extended Release 650 MG. Give 1 tablet by mouth every 8 hours as needed for pain. The MAR lacked documentation indicating Resident #11 didn't receive additional acetaminophen through review date of 8/13/25.6/9/25: Biofreeze Professional External Gel 5 % (Menthol Topical pain relief). Apply to painful areas topically every 6 hours as needed for pain management. The MAR lacked documentation indicating Resident #11 didn't receive the medication through the review date of 8/13/25.6/9/25: Diclofenac Sodium External Gel 1 % (Topical pain relief). Apply to painful areas topically every 6 hours as needed for pain management. The MAR lacked documentation indicating Resident #11 didn't receive the medication through the review date of 8/13/25.6/4/25: Monitor the use of opioid Medications. The initials (Y) indicate there are no adverse reactions (such as constipation, delirium, unsteadiness, anorexia, drowsiness) related to opioid Use. [NAME] in the nurses notes if symptoms are present, notify provider, and complete documentation every shift for pain.The Encounter Note regarding a regulatory visit authored by the facility's Medical Director dated 7/15/25 documented Resident #11 admitted to the facility on [DATE]. The note reflected Resident #11's pain level as a 0. It documented Resident #11 reported his pain worsened and the current dose of oxycodone 5 mg didn't help. The provider expressed concern for possible opioid dependency, with nursing requested to monitor and consider slow upward titration if pain remained uncontrolled. On 8/11/25 at 12:51 PM, Resident #11 stated he had pain ever since his stroke and back surgery. Resident #11 stated he used to take 10 mg, but they would only give him 5 mg. They did give him Tylenol but that didn't do shit. Resident #11 said they know I'm in pain. Resident #11 said he didn't know why they couldn't give him more. He rated his pain at a 7 or 8. He described his pain as down his left leg. Resident #11 gave permission to look into his pain management. Observed Resident #11 have facial grimacing when he rubbed his leg. On 8/12/25 at 12:32 PM, witnessed Resident #11 in his room sitting in a wheelchair. He reported his pain level at the time as a 7 or an 8. He stated at night it went up to a 10 and he hardly could sleep. He grimaced as he rubbed his leg and indicated he had pain in his leg. On 8/13/25 at 3:43 PM, questioned Staff D, MDS/Care Plan Registered Nurse (RN), about what they did for Resident #11's pain as he had constant in pain, she said well he is a drug seeker. Staff D explained he had a history of addiction and the providers know. When asked about interventions she said he received pain medication. On 8/14/25 at 9:37 AM, witnessed Resident #11 in his wheelchair wheeling down a hallway. He stated he felt pretty good that day and he had less pain. He rated his pain at a 6.On 8/14/25 on 9:45 AM, Staff K, Advanced Practiced Registered Nurse, stated she looked in to Resident #11's pain control. She stated she saw and talked with Resident #11 often. She stated she felt like he received the appropriate amount of Oxycodone. She stated she did a dosage reduction. She said he abused oxycodone at home by taking too much of it and then falling frequently. He ended up in the hospital and then came to the facility. She said she felt like he had his pain in control. She added the facility had so many interventions they could use to help with pain management as well. When told Care Plan had nonpharmalogical interventions, PRN Tylenol, and PRN ointments for pain, but the clinical record lacked documentation to indicate usage, he still had documented pain 4 times a day of a consistent 6 or 7, yet no documentation of interventions or refusals of them can be found, Staff K stated she believed if he had pain at a 7, he wouldn't be able to do some of the things he did. She described him as one of the facility's most active resident. He went out with his brother and family quite a bit. He went all over the facility and knew he could do physical therapy to help with pain management. She said Resident #11 didn't complain or present like he had pain to her. She said it is a balance between managing pain and being able to function. Especially for someone who had a history of opioid dependence and couldn't get the type of pain relief that stimulated the brain like opioids do. When told of observations of Resident #11 with facial grimacing, Staff K said when the medication started to wear down, the person could feel a sense of the pain not being controlled. She stated Resident #11 watched the clock and would ask for his pain pill every 6 hours. Staff K acknowledged the concern (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165367	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Care and Rehabilitation Center	501 South Kentucky Ave Mason City, IA 50401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding the consistent documentation of pain level at a 6 or 7, the Care Plan directed Resident #11 could tolerate a pain level of 5, and his clinical record didn't have documentation of refusals of interventions offered or tried. She stated that happened a lot at different facilities, when they have interventions put into place but staff would call and ask for more medication without trying any interventions. She acknowledged the facility should have offered interventions to Resident #11 with documentation of effectiveness or refusals. On 8/14/25 at 10:00 AM, the Director of Nursing (DON) and the Nurse Consultant acknowledged the concern of Resident #11's clinical record had consistent documentation of a pain level at a 6 or 7, the Care Plan directed Resident #11 could tolerate a pain level of 5, and the clinical record didn't have documentation of interventions refused when offered or tried.The Pain Policy revised September 2023, directed the facility would ensure to provide pain management to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered Care Plan, and the residents' goals and preferences. The Care Plan instructed the nurse to assess the resident for pain upon admission and readmission. For residents identified with pain upon the admission/readmission assessment, the nurse would receive an order for pain medication from the physician when non-pharmacological interventions aren't effective. If the resident need pain medication, they would receive medications as ordered. After the administration of PRN pain medication, the nurse would assess the resident for the effectiveness of the pain medication. If the resident still had unrelieved pain despite pharmacologic and nursing measures, the facility would notify the resident's physician. For chronic intractable (uncontrollable) pain, the physician may choose to refer the resident to a pain specialist for the resident's benefit. The facility would arrange the specialist's appointment once the attending physician ordered the referral. The nurse would refer the medications and interventions ordered by the pain specialist to the resident's attending physician for approval. Once available, the nurse would give the pain medication as ordered. The facility would monitor residents on opioids for signs and symptoms of overdose.