STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165536	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I O O F Home and Community Therapy Center	1037 19th Street SW 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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on record review, staff interview, and Resident Assessment Instrument (RAI) Manual the facility failed to ensure 2 of 4 residents (Resident #37 and #57) Significant Change Minimum Data Set (MDS) assessments were completed within 14 days of identifying a significant change occurred. The facility reported a census of 63 residents. Findings include: 1. Record review of Resident #37's Hospice Certification and Plan of Care dated 2/27/2024 documented he went on Hospice services on 2/27/24. Record review of Resident #37 Progress Notes revealed on 2/27/24 a hospice nurse came to the facility and signed Resident #37 up for hospice services. Record review on 3/19/24 of Resident #37's Significant Change MDS dated [DATE] revealed the MDS was not completed. Record review of the current RAI Manual dated 10/2023 on page 2-25 instructed the following: A Significant Change MDS is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The Significant Change MDS date must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). A Significant Change MDS must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving their highest practicable well-being at whatever stage of the disease process the resident is experiencing. 42134 (continued on next page)

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Clinical record review for Resident #57 revealed a certification for hospice services beginning on 2/19/24. The MDS for Resident #57 was signed as complete on 3/13/24. This is outside the required 14-day time frame. During an interview on 3/20/24 at 1:40 PM the MDS Coordinator explained she thought she had 14 days after a significant change was identified to set an Assessment Reference Date. She further explained she thought she had an additional 14 days to complete the MDS assessment. She acknowledged the MDS for Resident #57 was outside the 14 days required time frame. She stated the facility did not have a policy for MDS completion, they follow the RAI Manual.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 41537 Based on record review and staff interview the facility failed to ensure all diagnoses that were present on admission were on the Preadmission Screening and Resident Review (PASRR) upon admission to the facility for 1 of 1 residents (Resident #49). The facility reported a census of 63 residents. Findings include: Record review of Resident #49's PASRR dated 11/29/2023 documented resident had one (1) mental health diagnosis, major depressive disorder. Record review of Resident #49's current diagnosis upon admission to the facility on the, Transfer/Discharge Report dated 11/30/2023 included six (6) mental health diagnosis: pseudobulbar affect (episodes of sudden uncontrollable and inappropriate laughing or crying), delusional disorders, major depressive disorder, other symptoms and signs involving cognitive functions and awareness, adjustment disorder with mixed disturbance of emotions and conduct, and anxiety disorder due to known physiological condition. During an interview with the Social Worker on 3/20/2024 at 12:10 PM revealed Resident #49's PASRR did not include all of his current diagnosis and she just submitted a new PASRR to the local agency with all of his mental health diagnosis to review. During an interview with the Social Worker and Admission Coordinator on 3/20/24 at 12:41 PM revealed they do not currently have a process in place to compare and review new resident admission diagnosis and what's on the PASRR to ensure they match, but they are going to start now.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41537 Based on record review, staff interview, and policy review the facility failed to ensure 1 of 3 residents reviewed for catheters (Resident #37) Care Plan was updated to inform and instruct staff of the reason and how to care for his catheter. The facility reported a census of 63 residents. Findings include: Record review of Resident #37's Progress Notes on 2/28/24 revealed a new order for catheter. Record review of Resident #37's Telephone Order dated 2/28/24 revealed a new order for a catheter. Record review of Resident #37's current Care Plan on 3/19/24 did not include that he had a catheter. During an interview on 3/20/24 at 1:40 PM the MDS Coordinator revealed she would Care Plan if a resident would have a catheter placed while living at the facility, she stated she would put it on the Care Plan as soon as she found out about it. Review of an undated facility policy, Care Planning Comprehensive Care, lacked instruction on when to update Care Plans for changes in nursing care needs.

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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. 49976 Based on observation, policy review, and staff interview the facility failed to maintain safe holding temperatures of 135 degrees Fahrenheit for hot foods and under 41 degrees Fahrenheit for cold foods to prevent foodborne illness. The facility reported a census of 63. Findings include: Premeal temperatures taken on 3/19/24 at 11:42 AM revealed the pureed vegetables and gravy were not heated to an internal temperature of 135 degrees Fahrenheit (F) before being served to residents. The vegetables reached a temperature of 125.7 F and the gravy 134.7 F directly before being plated. Post meal temperatures taken at 12:32 PM revealed the following foods did not maintain the internal holding temperature of 135 F: a. Pureed vegetables (on unit): 125.1 F b. Ground Pork (on unit): 100.0 F c. Pork loin (on unit): 102.0 F d. Sweet potatoes (on unit): 128.0 F e. Gravy (on unit): 120.0 F An observation on 3/19/24 at 12:47 PM revealed the steam table was not plugged in on the back unit. The pork loin was placed on the counter, not on the steam table. An observation on 3/21/24 on the back unit from 7:48 AM to 8:26 AM revealed the milk set directly on the counter for the duration of the breakfast meal. The post meal temperature was 58.5 F. The undated facility policy titled Safe Food Preparation: Final Cooking Temperatures instructed staff to cook fresh, frozen, or canned fruits and vegetables to a hot holding temperature of 135 F to prevent the growth of pathogenic bacteria. It further delineated the use of a steam table to heat food as unacceptable. The undated facility policy titled Food Distribution: Tray line and Alternative Meal Preparation and Service Area instructed staff to avoid risks including holding foods in danger zone temperatures which are between 41 F and 141 F and using steam tables to heat food. It further instructed staff to reheat hot pureed, ground, or diced foods that have fallen below 141 F to reach 165 F for 15 seconds prior to serving. The undated facility policy titled Food Service and Distribution instructed staff to avoid food handling risks including food left on trays or countertops beyond safe time and/or temperature requirements. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/21/24 at 8:45 AM the Food Services Supervisor reported he expected foods to be cooked to the correct initial temperature indicated on the menu chart. Altered consistency foods must be brought back to temperature in the oven and then placed on the steam table. He expected anything not up to temperature upon cooking to go back into the oven before going on the steam table. He reported anything on the steam table needs to be 135 F or above for service. He explained milk must be on ice to keep below 41 F and cold items that can spoil must be kept under 41 F. He confirmed staff must follow the policies and have been trained on them.

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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. 49976 Based on observation, policy review, and staff interview the facility failed to keep the kitchen area clean, use gloves appropriately for assembling and serving meals, keep hands off the drinking surfaces of glasses, keep bare hands off of foods, and keep serving utensils clean in order to serve meals under sanitary conditions. The facility reported a census of 63 residents. Findings include: During an observation of the kitchen on 3/18/24 at 11:10 AM, food particles were present on the floor throughout the kitchen and on the bottom shelf of the steam table where resident insulated lids were stored. Food particles continued to be present during an observation on 3/19/24 at 11:13 AM. An observation on 3/20/24 at 11:06 AM revealed food particles on the floor and steam table along with crumbs on the counter near the clean plates, bread crumbs coating the counter near the toaster, and paper and a cleaning cloth on the floor near the dish washing station. During an observation of the noon meal on 3/18/24 from 11:52 to 12:38, Staff A, Environmental Aide, Staff B, Certified Nursing Assistant (CNA), Staff C, Certified Medication Aide (CMA), and the Food Services Supervisor (FSS) served 12 glasses to 7 residents in the main dining area handling the cups with fingers on the drinking rim surface of the glasses. During a continuous observation of puree preparation on 3/19/24 from 11:01 AM to 11:40 AM, Staff D, Dietary Staff failed to measure out portion sizes prior to pureeing the pork, mixed vegetables, and sweet potatoes. He then failed to measure the volume of the pureed pork, mixed vegetables, sweet potatoes, and cake after altering consistency. He divided the food into containers for the front and back dining rooms without measuring for the requisite number of residents. During a continuous observation of the puree preparation on 3/20/24 from 11:02 AM to 11:39 AM Staff E, Dietary Staff failed to measure the volume of the ground beef, pureed steak, and pureed cake after altering consistency. She divided the food into containers for the front and back dining rooms without measuring for the requisite number of residents. An observation of the noon meal preparation on 3/19/24 revealed the following: A. At 12:07 PM The FSS failed to secure the scoop for the sweet potatoes. The handle he touched with his bare hands fell into the dish. The affected food was then served to residents and the scoop was not replaced. B. At 12:16 PM Staff D wore gloves and touched a butter knife to spread butter onto a sandwich. He then failed to change gloves and touched the bread, meat, and cheese and assembled the sandwich. C. At 12:16 PM Staff H, Dietary Staff wore gloves to assemble a sandwich. He failed to change gloves after he touched the spatula to flip the sandwich and then used his hands to assist in turning it. He failed to change gloves after closing the lid of the cheese container and then touched the sandwich to plate it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. At 12:20 PM The FSS used tongs to remove the lid from a pan. He then used the tongs to take a burger patty out and then to place the lid back on. E. At 12:26 PM Staff H wore gloves and opened a chip bag. He failed to change gloves and then touched a hot dog and chips in the bag. F. At 12:38 PM Staff D wore gloves and untied and opened a bread bag. He failed to change his gloves and then touched bread. He failed to change his gloves after he opened the lid to the cheese container and then touched the cheese. An observation of the noon meal preparation on 3/20/24 revealed the following: A. At 11:58 AM Staff I, Dietary Staff wore gloves and took bread out of a bag. He then touched plates, the oven handle, and his glasses. He failed to change gloves and then retouched the bread. B. At 11:59 AM Desserts were transported uncovered to the back units. C. At 12:18 PM Staff G, Dietary Staff grabbed the food lid with her bare hand and placed it face down on the counter. She replaced the lid on the food with her bare hands and placed serving tongs on top of the food lid. She proceeded to serve 8 residents with the tongs. In an interview on 3/19/24 at 11:01 AM Staff D explained he eyeballs the number of slices and amounts of food to puree. He makes sure there is enough left for the residents on normal diets and goes from there. The undated facility policy titled Safe Food Preparation: Cross-Contamination instructed staff to clean and sanitize work surfaces and food-contact equipment between uses. The undated facility policy titled Food Distribution: Tray Line and Alternative Meal Preparation and Service Area instructed staff to avoid risks including handling food with bare hands or improperly handling equipment and utensils. The undated facility policy titled Food Distribution instructed staff to cover all foods transported through public corridors. The facility lacked a policy on handling of dishes, puree procedures, and use of gloves in food preparation. During an interview on 3/21/24 at 8:45 AM FSS indicated his expectation of the puree process was for staff to start with one more serving than needed, puree the food, divide it into the two serving tins for the front and back units, and use the indicated scoop size from the menu book to serve the food. He further acknowledged that he had not considered the reduction in volume. He voiced he was not aware of the pureed diet portion sizes chart. He reported he expected staff to clean as they go and clean the whole area after each shift. He confirmed staff must wear gloves when handling ready to eat foods or assembling a sandwich. They are not to touch multiple surfaces when wearing gloves. He expected staff to use tongs to get bread or chips out of bags. They are not to use the same tongs to get both items. Staff are not to touch any food bare handed. He explained they are to handle the bottom half of cups and not on the rim where residents put their mouths. He confirmed staff must follow the policies and have been trained on them. 42134 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation on 3/18/24 at 12:26 PM Staff G removed the crust from a slice of garlic bread with her bare hands, without performing hand hygiene, and served it to Resident #45. During an observation on 3/18/24 at 12:32 PM Staff G removed the crust from a slice of garlic bread with her bare hands, without performing hand hygiene, and served it to Resident #13. During an observation on 3/18/24 at 12:33 PM Staff G removed the crust from a slice of garlic bread with her bare hands, without performing hand hygiene, and served it to Resident #66. During an observation on 3/18/24 at 12:39 PM Staff G removed the crust from a slice of garlic bread with her bare hands, without performing hand hygiene, and served it to Resident #2.

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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. 48003 Based on facility record review and staff interviews, the facility failed to provide satisfactory evidence that they identified their own high risk, high volume, and problem-prone quality deficiencies, and made a good faith attempt to correct them. The facility reported a census of 63 residents. Findings include: Review of the facility records, revealed repeated deficient practices identified during the facility's previous survey completed on 12/15/22, during a complaint and facility reported incident survey completed on 8/11/23 and current survey investigations. During an interview on 3/21/24 at 10:28 AM, the DON reported QA meets monthly and go over each department's areas, audit and concerns. She reports prior deficiencies from previous surveys are talked discussed at the meeting. Each month will go over the concerns and the corrective actions in place. The QAPI Plan dated August 2023 directed the facility will examine and improve care or services in areas that are identified as needed attention. It directs the committee meets monthly to go over the plan, interventions and continue to monitor the effectiveness.