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	03/13/2025

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

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003 Based on clinical record review, facility document review, and staff interview the facility failed to send notice to the State Long Term Care Ombudsman for hospitalization s for 3 of 3 residents (Residents #2, #27 and #64) reviewed. The facility reported a census of 71 residents. Findings include: 1. Resident #2's Census List reviewed on 3/11/25 reflected she discharged to the hospital on 12/24/24 and returned to the facility on [DATE]. The General Nurses Note written on 12/24/24 at 3:15 PM identified an ambulance took Resident #2 to the hospital. The General Nurses Note written on 12/24/24 at 9:59 PM documented the hospital admitted Resident #2 to the hospital for outpatient observation. The N ADV Clinical Admission Note completed on 12/26/24 at 1:30 PM reflected Resident #2 returned to the facility. The Notice of Transfer Form to Long Term Care Ombudsman for December 2024 lacked documentation of Resident #2's transfer to the hospital. 2. Resident #27's Census List reviewed 3/13/25 identified he transferred to the hospital on 11/20/24 and returned to the facility on [DATE]. The General Nurses Note written on 11/20/24 at 7:30 AM reflected Resident #27 transferred to the hospital by ambulance. The N ADV Clinical Admission Note written on 11/22/24 at 2:16 PM identified Resident #27 returned from the hospital. The Notice of Transfer Form to the Long-Term Care Ombudsman report for November 2024 lacked documentation of Resident #27's transfer to the hospital. (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

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	03/13/2025

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

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #64's Census List reviewed 3/13/25 indicated she transferred to the hospital on 1/19/25 and returned to the facility on [DATE]. The General Nurses Note written on 1/19/25 at 2:15 PM reflected Resident #64 transferred to the hospital. The General Nurses Note written on 1/19/25 at 6:32 PM identified Resident #64 admitted to the hospital. The N ADV Clinical Admission Note completed on 1/27/25 at 1:52 PM reflected Resident #64 returned to the facility. The Notice of Transfer Form to the Long-Term Care Ombudsman report for January 2025 lacked documentation of Resident #64's transfer to the hospital. In an interview on 3/12/25 at 2:50 PM Staff A, License Practical Nurse/ Admissions Coordinator, reported she added the residents to the Ombudsman's report each month who have discharged . She reported she didn't know that anything else needed to be on the report such as hospitalization s so she missed putting the residents on the list.

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	03/13/2025

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

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on record review, staff interview the facility failed to complete a discharge Minimum Data Set (MDS) for 1 of 5 residents reviewed (Resident #2) for discharge. The facility reported a census of 71 residents. Findings include: Resident #2's Census List reviewed on 3/11/25 reflected she discharged to the hospital on 12/24/24 and returned to the facility on [DATE]. Resident #2's MDS log reviewed 3/11/25 reflected a quarterly MDS assessment on 10/11/24 with a Entry MDS assessment on 12/26/24. The list lacked an assessment completed for her discharge on 12/24/25. The electronic health record listed the next tracking/discharge due as: Discharge - assessment reference date (ARD) 12/24/24, 63 days overdue. During an interview on 3/13/25 at 9:49 AM the MDS Coordinator reported she didn't know Resident #2 discharged to the hospital and if she could complete a late MDS. During an interview on 3/13/25 at 9:57 AM the Director of Nursing (DON) explained the MDS Coordinator would complete a late discharge MDS for Resident #2 that day to comply. She added she expected the MDS assessment get completed timely.

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	03/13/2025

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

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on observation, record review, staff interviews and policy review the facility failed to ensure 1 of 3 residents with a facility acquired pressure ulcer were provided with proper assessment and treatment to prevent pressure ulcers while living at the facility (Resident #66). The facility reported a census of 71 residents. The facility fixed the concern on 3/7/25, prior to the survey start through the following action plan: a. 2/27/25: The Director of Nursing (DON), or Assistant Director of Nursing (DON) if the DON is absent, would double check all new admission/readmission orders. b. 2/28/25: The facility checked all residents to ensure no other residents affected. c. 3/7/25: Anytime a resident has an order to wear any device fitted on a resident extremity (such as a brace), the standing order will be for the nurse to remove or loosen the device and check the skin twice a day. d. 3/7/25: Unit managers to check details of any new device/brace orders entered in the electronic health record (EHR) to ensure nurse will check the skin under the device twice a day. e. 3/7/25: Each nursing station will have skin monitoring forms for the Certified Nurse Aides (CNA). The facility conducted a meeting to remind staff of how to use the form. Findings include: Resident #66's Minimum Data Set (MDS) assessment dated [DATE] listed an admitted [DATE]. The MDS identified a Brief Interview of Mental Status (BIMS) score of 12, indicating mild cognitive impairment. Resident #66 required total assistance from staff for toileting, showering, bathing, and dressing. Resident #66 couldn't stand, transfer to the toilet or walk. The MDS included diagnoses of cancer, hypertension (high blood pressure), anemia (low blood iron levels), diabetes mellitus, bacteriuria (bacteria in the urine), and a left hip fracture. The MDS reflected Resident #66 had a risk for developing pressure ulcers/injuries. At the time of assessment Resident #66 didn't have one or more unhealed pressure ulcers/injuries. Resident #66 received an antihyperglycemic medication during the lookback period. The N ADV Clinical Admission Note dated 12/31/24 at 1:45 PM indicated Resident #66 had a knee immobilizer on her upper leg and a bilateral Podus boots (specialized boots used to prevent pressure to the heels and hip rotation) to be worn at all times. The functional note listed Resident #66 as non-weight bearing (NWB) on the left lower extremity and used an immobilizer on her left leg. Resident #66's Hospital Clinical Summary dated 12/31/24 listed her transfer orders for restricted activities as toe-touch weight bearing to her left lower extremity with a knee immobilizer on at all time. Remove/loosen brace for twice daily skin checks. (continued on next page)

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	03/13/2025

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

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #66's January 2025 Treatment Administration Record (TAR) lacked the restricted activities order for the toe-touch weight bearing, the knee immobilizer, and the removal of the brace twice daily for skin checks. The TAR did include an order dated 12/31/24 to apply Eucerin Advanced Repair cream to both of her legs every morning and night for dryness. The Doctor Visit Form dated 1/9/25 reflected the facility requested to get a second immobilizer due to Resident #66 complaining of extreme pain to her leg. The provider responded the fracture appeared stable, continue with care - NWB, toe-touch weight bearing for balance. No knee range of motion (ROM), may do quad sets with knee brace on. The Doctor Visit Form dated 1/20/25 listed the reason for visit as follow-up visit with orthopedics. The doctor's instructions directed NWB to left lower extremity, follow-up in 6 weeks, keep left knee immobilizer on at all times (may remove for hygiene, showers, and home physical therapy (PT) exercises. The additional comments included to avoid falls, ice, and elevation. The 2/6/24 Encounter Note completed by Staff F, Advanced Registered Nurse Practitioner (ARNP) documented Resident #66 used an immobilizer. The assessment of the skin reflected it as dry, with no unusual rashes, lesions, or excessive bruising. The note reflected the leg had normal color with the immobilizer intact to her left lower extremity. The Doctor Visit Form dated 2/24/25 listed the reason for visit as follow-up with orthopedics. The doctor's instruction section included to continue toe-touch weight bearing to her left lower extremity for 6 weeks, follow-up in 6 weeks, and additional PT orders. Resident #66's February 2025 TAR included the following orders: a. Eucerin Advanced Repair Cream dated 12/31/24 - apply to bilateral lower extremities every morning and bedtime for dryness. b. Hinge Brace on left knee at all times dated 2/25/25, discontinued 2/26/25. c. Per provider dictation on 2/24/25 Left leg hinged knee brace to be worn at all times dated 2/26/25: Can be removed for showers only. The Incident Report dated 2/25/25 at 1:45 PM identified Resident #66 had a skin issue that measured 8 centimeters (cm) by (x) 3 cm x 0.1 cm with a small amount of red drainage. The provider gave an order for cephalexin (antibiotic) 500 milligrams (mg) 4 times a day for 7 days for wound healing. The report listed the root cause as wearing left leg immobilizer at all times until 2/24/25. The untitled handwritten document dated 2/25/25 written by Staff C, Certified Nurse Aide (CNA), documented she did care on Resident #66 daily and she didn't see any open areas on her when Staff D, CNA, gave her a bath the week before. She added Resident #66 didn't have her brace on at the time and she didn't see any open areas. Staff C reported that day as the first time she ever saw an open area to her lower leg. The untitled handwritten document dated 2/26/25 by Staff B, Registered Nurse (RN), documented on 2/24/25 she removed Resident #66 boot and socks to lotion her lower extremities (legs). At that time, she saw her legs dry and scaly but she didn't notice any open wounds. (continued on next page)

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	03/13/2025

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

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The untitled handwritten document dated 2/26/25 by Staff D documented on 2/19/25 she gave Resident #66 a bath and removed her leg brace from her leg and applied lotion to them, she didn't see a sore. The 2/27/24 Encounter Note completed by Staff F, Advanced Registered Nurse Practitioner (ARNP) documented Resident #66 had a new skin concern the nursing staff found on 2/25/25. The note described the area as an unstable pressure ulcer on her left lower extremity caused by the bar of her knee immobilizer. The area measured 8 cm x 3 cm x 0.1 cm with cellulitis from the knee to the ankle. The wound had a small amount pink drainage. The wound had 70% slough (dead, non-viable tissue that forms on the surface of a wound), 25% eschar (dead tissue that appears dry, thick, and leathery, often appearing tan, brown, or black) and 5% granulation tissue (a type of new, temporary tissue that forms in response to an injury or wound). During an interview on 3/12/25 at 2:38 PM the Director of Nursing reported she didn't have documentation that the facility staff completed twice a day assessments for the removal of the immobilizer. A letter written by Staff F dated 3/13/25 reflected Resident #66 had an unstageable pressure ulcer to her left lateral lower extremity. The nursing staff noted the wound on 2/25/25. Staff F suspected the appearance and quick deterioration of the wound is secondary to the underlying comorbidities (multiple diagnoses), including type 2 diabetes and a history of chondrosarcoma s/p (has a history of chondrosarcoma, a rare type of tumor that usually begins in the bones, and went through a form of treatment, like surgery, radiation, or chemotherapy), and current immobility secondary to left femur fracture being conservatively managed and known poor nutritional intake. Resident #66 has thick scales of hyperkeratosis (a condition characterized by thickening of the outermost layer of skin (stratum corneum) due to an overproduction of keratin, often appearing as calluses, corns, or rough patches) on her left lower extremity that likely masked any developing concerns with tissue integrity. During an interview on 3/13/25 at 11:35 AM the Administrator explain he expected the staff to document on the TAR the completion of twice a day removal and skin assessment of Resident #66's immobilizer.