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	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altoona Nursing and Rehabilitation Center	200 Seventh Avenue SW Altoona, IA 50009

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure staff protected and prevented resident to resident abuse for 1 of 3 reviewed (Resident #7), when Resident #6 hit Resident #7 a couple of times in the back while in the main lobby area. Resident #7 had a known history of resident-to-resident altercations and the facility failed to evaluate the effectiveness of the interventions to prevent harm to other residents. The facility reported a census of 97 residents. Findings include: 1. Resident #6's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 10 indicating moderately impaired cognition. The MDS included diagnoses of dementia and diabetes. Resident #6's Care Plan documented a problem with the revision date of 11/21/24 as follows; the Resident had episodes of behaviors as evidenced by negative verbalizations, name calling, cursing at others, aggressive behaviors toward other residents, tearfulness, rude statements, and refusing care. The following Care Plan entries documented interventions completed, and Interventions for staff related to the residents behaviors;a. 10/13/24: verbal aggression initiated by Resident #6 towards another residents and physical aggression returned to Resident #6 then Resident #6 returned physical aggression to other the resident. Residents separated and will be living in separate areas of the building.b. 11/4/24: aggression initiated by Resident #6 at another resident. Residents separated and seated at different tables. c. Intervene as necessary to protect the rights and safety of the other residents. Approach/ speak in a clam manner, divert attention if needed. Remove from thesituation and take to alternate location as needed. Initiated 8/4/23d. Observe and chart behaviors as necessary and report to the physician. Initiated 8/4/23e. Observe for early warning signs of oncoming behaviors. Approach in a calm manner, call by name and remove from unwanted stimuli. Initiated 8/4/23f. Refer to psychological/psychiatric consults as indicated. Initiated 8/4/23. On 10/29/25 continuous observation of the dining room from 12:00 PM to 12:40 PM revealed staff in and out of the area. Most of the time when the nurses were in the dining area, they were faced away from the residents at the medication carts in the area. At 12:25 PM Resident #6 yelled at another resident in the dining room pull up your pants you fat ass. No staff were present at the time of the incident. The Facility Investigation dated 10/27/25 documented that on 10/24/25 at approximately 3:15PM Staff A, Registered Nurse (RN) observed Resident #6 strike Resident #7 on the back a couple of times in the main lobby area. The residents were separated immediately and the Administrator notified. Further investigation determined Resident #6 was coming out to the main lobby to sit at her table when she noticed Resident #7 sitting there. Resident #6 reported she used cuss words toward Resident #7 and told him to move out of her spot. When Resident #7 began moving he backed his wheelchair into Resident #6 because he didn't like how Resident #6 was speaking to him, which resulted in Resident #6 striking Resident #7 in the back. The residents were separated by staff and were redirected safely to their respective areas. On 10/29/25 the surveyor requested all (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
	165162	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altoona Nursing and Rehabilitation Center	200 Seventh Avenue SW Altoona, IA 50009

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6's incident reports from resident-to-resident altercations from the Director of Nursing (DON). Resident #6's Progress Notes documented the following;a. 10/6/24 at 12:08 PM Resident #6 noted the last two days, picking on another female resident. If she is in her way of getting thru to her table, she shoves her wheelchair to move her so she can get through. Today Resident #6 shoved her again and stated You dumb bitch, get out of my way. Staff spoke with Resident #6 about the way she was treating the other resident and reminded her that she cannot put her hands on anyone or anyone's wheelchair and not shove her or anyone else. Resident #6 stated well you think she can get out of the way, what do you want me to do, go all the way around? Staff reported to Resident #6 that she could do that or even ask the individual to move so she could get thru. b. 10/14/25 at 12:45 PM Resident #6 yelled Fuck you to a resident who didn't hear what she stated to her, so Resident #6 was upset with her. The other resident was asked to move to another table for lunch so that Resident #6 wasn't tempted to yell at her again.c. 10/29/25 at 10:14 AM Resident #6 verbal towards tablemate, stating Why don't you fucking shut your mouth. Resident #6 was asked to move to another table at breakfast, and did so willingly. Resident #6 also stated to this nurse Shut the fucking ice container, the ice will melt.d. 11/2/25 at 12:53 PM Resident #6 telling another resident to Shut up. Reminded Resident #6 that it isn't appropriate to say that to other residents. Resident #6 states Then she needs to just go to her room.e. 3/18/25 at 4:58 PM: Resident #6 upset that a resident was sitting by her table and she wanted her moved as She's looking at me. Reminded Resident #6 that every resident has the right to sit where they want in the lobby and that she can look at her. Resident #6 states No she can't move the old dinosaur. Reminded Resident #6 again not appropriate to call other resident's names. States I don't give a shit.f. 3/22/25 at 2:39 PM Resident #6 was verbal toward another resident. Telling the other resident to shut up, you don't belong here. Resident #6 then proceeded to push the other resident (in her wheelchair) into the table the other resident was sitting at. Resident #6 was reminded by staff it was inappropriate and not to touch another resident or tell them to shut up. g. 4/20/25 4:56 PM Resident #6 kicked another resident's walker because it was next to the spot where Resident #6 sits for meals. The other resident went to another table and Resident #6 yelled at him telling him to pull his pants up.h. 4/21/25 at 3:08 PM Resident #6 was cursing and yelling at a resident trying to get on the dining table where she was sitting during breakfast. The other resident was asked to move to a different table.i. 5/15/25 at 10:37 PM Resident #6 being rude to another resident in the dining hall. Resident #6 did not like another resident in the dining hall and shoved his concentrator. Resident #6 moved away and no further issues.j. 9/27/25 at 11:35 AM Resident #6 was witnessed showing her middle finger to another resident and calling him a foul name. Redirection given and education with teach back.The residents clinical record lacked a root cause analysis, and resident center approach to assist the facility staff members from decreasing or preventing reoccurring resident-to-resident incidents that involved Resident#6. On 10/29/25 at 10:40 AM the DON reported they did not have incident report for the 10/6/24 and 3/22/25 resident to resident altercations due to no one being hurt. On 10/29/25 at 1:25 PM the DON reported the 10/24/25 incident where Resident #6 hit another resident, the intervention was separation. She reported there was no other inventions put in place because they could not remove Resident #6 from the dining room because of her rights. She reported the facility did not look at any other inventions. On 10/29/25 at 2:10 PM Staff E, Certified Nurses Aide (CNA) reported that Resident#6 yelled at other residents, but she had never seen her hit anyone. She stated that the other residents just know not to sit at her table.On 10/29/25 at 2:15 PM Staff F, Certified Medication Aide (CMA) reported that Resident#6 yelled a lot and it is due to residents sitting at her table, Resident#6 doesn't like anyone in her area in the dinning area. Staff (continued on next page)

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	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altoona Nursing and Rehabilitation Center	200 Seventh Avenue SW Altoona, IA 50009

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F, reported that just know to stay away. On 10/29/25 at 2:40 PM Staff B, Licensed Practical Nurse (LPN) reported she could not recall who the other resident was for the 10/06/24 or the 3/22/25 incidents. Staff B reported she could not recall if the resident on 3/22/25 hit the table or not. Staff B reported she did not fill out an incident report but if the resident would have been hurt, she would have. Staff B verbalized Resident #6 is possessive of her spot in the dining room/main lobby area. Staff B reported Resident #6 doesn't want anyone to sit at her spot ever. The Nursing Abuse Prevention, Identification, Investigation and Reporting Policy dated 7/8/24 directed staff as follows: Rational: All Residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This includes prohibiting nursing facility staff from taking acts that result in person degradation, including the taking or using photographs or recording in any manner that would demean or humiliate a resident, and prohibits using of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep or distribute photographs and/or recording on social media or through multimedia messages. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. -Physical abuse includes, but not limited to hitting, slapping, pinching, and kicking. It also includes corporal punishment when used to correct or control behavior, including but not limited to, pinching, spanking, slapping hands, flicking, or hitting with an object. - Resident-to-resident physical contact that occurs, which includes but is not limited to where residents are hit, slapped, pinched or kicked and results in physical harm, pain or mental anguish is considered resident-to-resident abuse. Resident-to-resident sexual harassment, sexual coercion, or sexual assault is also considered abuse. The facility will presume that instances of abuse caused physical harm, or pain or mental anguish in residents with cognitive and/or physical impairments which may result in a resident unable to communicate physical harm, pain or mental anguish, in the absence of evidence to the contrary. An example would be a resident slapping another resident who is physically or cognitively impaired, even though the resident who was slapped showed no reaction (e.g., yelp or grimace), it is presumed the resident experienced pain. 2. Resident #7's MDS assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 10 indicating moderately impaired cognition. The MDS included diagnoses of dementia and hypertension (high blood pressure). On 10/30/25 at 11:00 AM Resident #7 reported he had an altercation in the dining room on the other end recently with Resident #6 due to Resident #6 being mean toward him. Resident #7 reported Resident #6 is crazy. Resident #7 reported he was not doing anything but sitting at a table enjoying his afternoon. Resident #7 reported he never wants to go back to that area because Resident #7 is crazy to deal with.

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	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altoona Nursing and Rehabilitation Center	200 Seventh Avenue SW Altoona, IA 50009

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, Resident Council Minutes, resident and staff interviews, the facility failed to answer resident call lights within the allotted professional standard of 15 minutes for 3 of 5 residents reviewed (Resident #3, #4 and #11) . The facility reported a census of 97 residents. Findings include: 1. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12 indicating moderately impaired cognition. The MDS documented Resident #4 was dependent (helper does all the effort. Resident does none of the effort to complete the activity. or , The assistance of 2 or more helpers is required for the resident to complete the activity) for toileting and transfers. The MDS included diagnoses of hemiplegia (paralysis affecting left nondominant side of body), anxiety and respiratory failure. During a continuous observation on 10/28/25 from 9:20 AM to 10:00 AM the following was revealed; note at 9:20 AM Resident #4's call light on. At 9:40 AM the Assistant Director of Nursing yelled out and asked the resident from the doorway what his light was on for. Resident #4 reported he wanted to get to his recliner. At 9:50 AM two Certified Nurses Aides (CNA) went in to assist the resident. On 10/19/25 at 9:33 AM Resident#4 reported he had waited up to an hour and a half at times for his call light to be answered. Resident #4 reported he watched his clock to see how long it takes at times. Resident #4 verbalized it is different this week due to the state surveyors in the building and reported there is not normally office staff answering the call lights like they have been today. Resident #4 reported management knows about the call lights but nothing changes. Review of the Resident Council Meeting minutes for August, September and October of 2025 documented residents voiced the following; long waits for call lights, staff telling residents they will be back and not returning and being left on the toilet 30+ minutes. The minutes lacked follow up documentation with the concerns of call lights, staffing and being left on the toilet. On 10/30/25 at 11:15 AM Staff C, CNA reported there is not enough staff at times to get call lights answered timely. Staff C verbalized she tries to get them in time but it doesn't always happen.On 10/30/25 at 11:20 AM Staff D, CNA reported not enough staff, and sometimes they are short staffed with call ins.On 10/30/25 at 11:50 AM the Director of Nursing (DON) and Administrator reported they expect staff to answer the call light within 15 minutes. 2. Resident #3's MDS assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13 indicating intact cognition. The MDS documented Resident #3 was dependent (helper does all the effort. Resident does none of the effort to complete the activity. or , The assistance of 2 or more helpers is required for the resident to complete the activity) for toileting and transfers. The MDS included diagnoses of diabetes, hip fracture and depression. Continuous observation on 10/28/25 from 6:50 PM to 7:17 PM noted Resident #3 call light on when turning down the hallway toward Resident #3's room. At 7:17 PM staff went in to answer the call light and assisted the resident while she was on the commode. On 10/28/25 at 7:10 PM Resident #3 reported it can be hours for her call light to be answered. Resident #3 reported that sometimes she had to call the facility to get someone to her room. Resident #3 reported she had voiced it to management but nothing changes. 3. Resident #11's MDS assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13 indicating intact cognition. The MDS documented Resident #11 was dependent (helper does all the effort. Resident does none of the effort to complete the activity. The assistance of 2 or more helpers is required for the resident to complete the activity for toileting and transfers. The MDS included anxiety and cancer for a diagnoses. During a continuous observation on 10/30/25 at 11:15 AM to 11:40 AM. At 11:18 AM noted Resident #11 call light on. At 11:25 AM the DON walks past the room of Resident #11 and sees the call light (continued on next page)

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	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altoona Nursing and Rehabilitation Center	200 Seventh Avenue SW Altoona, IA 50009

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on but does not stop. At 11:35 AM a CNA went in with the EZ stand machine and left the machine. CNA reported he would be back when he got another staff member. At 11:39 AM staff came back in to assist the resident. On 10/30/25 at 11:37 AM Resident #11 reported to this surveyor it is sometimes two to three hours for her call light. She then pointed to the clock under her tv and said she times it. This was while in the Ez stand waiting for the staff to return.

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	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altoona Nursing and Rehabilitation Center	200 Seventh Avenue SW Altoona, IA 50009

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review and staff interview, the facility failed to complete incident reports or document for 2 of 3 resident-to-resident altercations reviewed (Resident #6). The facility reported a census of 97 residents. Findings include: Resident #6's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 10 indicating moderately impaired cognition. The MDS included diagnoses of dementia and diabetes. Resident #6's Progress Notes documented the following:a. 10/6/24 at 12:08 PM Resident #6 has been noted the last two days, picking on another female resident. If she is in her way of getting thru to her table, she shoves her wheelchair to move her so she can get through. Today Resident #6 shoved her again and stated You dumb bitch, get out of my way. Staff spoke with Resident #6 about the way she was treating the other resident and reminded her that she cannot put her hands on anyone or anyone's wheelchair and not shove her or anyone else. Resident #6 stated well you think she can get out of the way, what do you want me to do, go all the way around? Staff reported to Resident #6 that she could do that or even ask the individual to move so she could get thru. b. 3/22/25 at 2:39 PM Resident #6 was verbal toward another resident. Telling the other resident to shut up, and you don't belong here. Resident #6 then proceeded to push the other resident (in her wheelchair) into the table the other resident was sitting at. Resident #6 was reminded by staff it was inappropriate and not to touch another resident or tell them to shut up. On 10/29/25 at 10:40 AM the Director of Nursing (DON) reported they did not have incident reports for the 10/6/24 and 3/22/25 resident-to-resident altercations due to no one being hurt. On 10/29/25 at 1:25 PM the DON reported the 10/24/25 incident where Resident #6 hit another resident, the intervention was separation. She reported there was no other inventions put in place because they could not remove Resident #6 from the dining room because of her rights. She reported the facility did not look at any other inventions. On 10/29/25 at 2:40 PM Staff B, Licensed Practical Nurse (LPN) reported the 10/6/24 and the 3/22/25 incidents she cannot recall who the other resident was. Staff B reported she did not chart or follow up with other residents involved in either of incidents. Staff B reported she could not recall if the resident on 3/22/25 hit the table or not. Staff B reported she did not fill out an incident report but if the resident would have been hurt she would have. Staff B verbalized Resident #6 is possessive of her spot in the dining room/main lobby area. Staff B reported Resident #6 doesn't want anyone to sit at her spot ever. Staff B reported looking back she should have charted on both residents. The Accident and Incidents-Investigating and Reporting Policy dated July 2017 directed staff as follows: Policy Statement: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation and Implementation: a. The Nurse Supervisor/ Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. b. The following data, as applicable shall be included on the Report of Incident/Accident form: date and time of accident or incident , circumstances surrounding the accident or incident, where the accident or incident took place, who was involved, condition of who was affected, corrective action taken, and follow-up information.c. The Incident/Accident report will be reviewed by the Safety Committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities.