

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165173	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Osage Rehab and Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 830 South Fifth Street Osage, IA 50461	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003</p> <p>Based on resident interviews, staff interviews and policy reviews, the facility failed to ensure staff treated residents with dignity and respect for 1 of 5 residents reviewed (Resident #5). The Facility reported a census of 33 residents.</p> <p>Findings include:</p> <p>Resident #5's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) Score of 14 indicating intact cognition. The MDS included diagnoses of hypertension (high blood pressure), diabetes, schizoaffective disorder (mental health disorder), borderline personality disorder (mental health disorder), anxiety and traumatic brain injury.</p> <p>During an interview on 4/8/24 at 1:22 PM, Staff C, Certified Nurse Aide (CNA), reported about a month ago she was in a room assisting Staff B, CNA, with Resident #5 to change her. During the process Staff B told Resident #5 you smell like piss. Staff C reported after they were done changing the resident and Staff B left the room, Resident #5 cried because she was upset about what Staff B said to her. She then reported it to the Administrator.</p> <p>On 4/9/24 at 8:45 AM, Resident #5 reported Staff B, CNA about a month or so ago told her she smelled like piss. She reported Staff B told her almost every time she changed her.</p> <p>During an interview on 4/9/24 at 9:32 AM, the Director of Nursing reported she expected all staff to treat residents with dignity and respect.</p> <p>Review of the facility's policy titled Residents Rights and Responsibilities with a revised date of February 2015 lacked documentation of residents being treated in a dignified manner by staff.</p>

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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48003</p> <p>Based on observation, policy review, and staff interview, the facility failed to serve food under sanitary conditions, in order to reduce the risk of contamination and food borne illness. The facility reported a census of 33 residents.</p> <p>Findings include:</p> <p>On 4/8/24 at 5:30 PM, observed Staff D, Cook, wash her hand and applied gloves. Staff D started the supper service, she touched the containers of pasta salad and fruit to remove the lids off of both containers with the gloved hands. Staff D then grabbed a resident's menu they filled out and set in front of her on the steam table. Staff D grabbed a plate and set it on the counter and took a chicken salad sandwich out of the pan placing it on the plate. Staff D then took the utensil and dished up pasta salad on to the plate and then with a different utensil dished up the fruit into a bowl. Staff D then with the gloved hands grabbed a cookie and wrapped it up and placed it all on a tray. Staff D proceeded to do then same thing with the next 15 resident's meals going between surfaces touching the menu, plates, bowls, utensils and food with the gloved hands. Staff D did not change her gloves throughout this process.</p> <p>On 4/8/24 at 5:42 PM, observed Staff E, Dietary Aide, observed adjusting his ballcap he was wearing and without doing hand hygiene then grabbed two glasses and orange juice in one and milk in the other glass. Staff E then grabbed the glasses by the rim and deliver them to a resident. Throughout the meal service Staff E did not perform hand hygiene and delivered 12 residents' drinks by carrying the glasses by the rim.</p> <p>On 4/8/24 at 5:51 PM Staff D, Cook, observed with the same gloves in which she has been wearing since the start of meal service open the refrigerator with the gloved hands and pull out a wrapped sandwich and set it aside on the counter. Staff D with the same gloved hands continued to serve residents by handling the chicken salad sandwiches with the gloved hands and grabbing cookies with the gloved hands. Staff D went to the refrigerator two other times during meal serve with the same gloved hands touching the refrigerator handles and not changing gloves nor doing any hand hygiene between surfaces. Several staff members throughout the meal service opened and got things out of the refrigerator.</p> <p>The Sanitation policy revised June 2015 directed the staff to change gloves with each new task. The policy lacked direction of hand hygiene between gloves and glove changes between surfaces.</p> <p>During an interview on 4/9/24 at 12:19 PM, the Dietary Manager reported she expected the staff to use utensils when serving food and not to use gloves when handling food during serving.</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>48003</p> <p>Based on personnel file reviews, facility policy review and staff interview, the facility failed to assure 2 of 6 staff met the requirements for Dependent Adult Abuse Training (Staff A and Staff B). The facility reported a census of 33 residents.</p> <p>Findings include:</p> <p>Review of Staff A, Certified Medication Aide (CMA), personnel file revealed a Dependent Adult Abuse training completed on 1/9/19 and was good for five years from the date in which would need to be completed by 1/9/24. The file lacked any further Dependent Adult Abuse training.</p> <p>Review of Staff B, Certified Nursing Assistant (CNA), personnel file with the start date of 3/16/23 lacked any documents of Dependent Adult Abuse Training.</p> <p>On 4/9/24 at 1:27 PM the Administrator reported Staff A, CMA, and Staff B, CNA, were completing the training right now but acknowledged it was late.</p> <p>The Abuse Prevention Program & Reporting policy revised April 2023 directed each employee shall be required to complete two hours of training relating to the identification and reporting of dependent adult abuse within six months of initial employment. Each employee shall complete at least two hours of additional dependent adult abuse identification and reporting training every three years.</p>