STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165173	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Rehab and Health Care Center	830 South Fifth Street Osage, IA 50461

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25854 Based on clinical record review, staff interview and policy review the facility failed to implement Care Plans for one (1) resident reviewed (Resident #6) The facility reported a census of 31 residents. Findings include: Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The Care Plan Focus revised 10/11/23 indicated Resident #6 had a risk for falling related to gait/balance problems, and incontinence. The Interventions directed to have the call light in reach and encourage her to use as needed (PRN). Resident #6 required prompt response to all requests for assistance. During an interview on 2/27/25 at 3:30 PM Resident #6 reported a couple weeks ago she timed the time it took for someone to answer her call light, it stay on from approximately 1:30 AM till 5:30 AM. At that time, she used her cell phone which gave her a feeling of anger and tired of being ignored. Resident #6 added other times she timed her call light on for 45 minutes on the 3rd shift which caused her to lose control of her stool (bowel movement) so she sat in her own poop, this caused her to feel unhappy because if the staff answered her light timely she wouldn't become incontinent. The Care Plans, Comprehensive Person Centered policy dated 2001 instructed a comprehensive, person centered Care Plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needed developed and implemented for each resident.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 25854 Based on clinical record review, staff interview and facility policy review the facility staff failed to follow Physician Orders for 1 of 3 residents reviewed (Resident #3). The facility identified a census of 31 residents. Findings include: A faxed Physician Order form signed by the Physician on 1/29/25 reflected Resident #3 received six (6) marks (bites) on her left arm from her cat that measured 0.1 centimeters (cm) by (x) 0.1 cm. The Physician ordered the staff to cleaned the areas on the resident's left hand with normal saline, apply by Triple Antibiotic Ointment (TAO) and cover with a bandage two (2) times a day (BID) and as needed (PRN) until healed. Resident #3's January and February 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) forms lacked the prescribed treatment orders, indicating the treatment didn't get completed as ordered. According to an email 3/4/25 at 1:56 PM the Administrator indicated Staff A, Licensed Practical Nurse (LPN), confirmed the January and February 2025 MARs and TARs didn't have the treatment order. The facilities Medication and Treatment Orders policy revised July 2016 directed the facility staff the need for orders of medications and treatments be consistent with principles of safe and effective order writing. The Policy Interpretation and Implementation instructed to administer medications only upon written order of a person duly licensed and authorized to have prescribed such medication.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25854 Based on observation, clinical record review, staff interview and resident interview, the facility staff failed to maintain appropriate nursing supervision to prevent a cat bite which resulted in a wound infection for one (1) resident reviewed. (Resident #3) The facility identified a census of 31 residents. Findings include: Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief interview for Mental Status (BIMS) score of 6, indicating severely cognitive impairment. The MDS listed Resident #3 as independent with most activities of daily living (ADLs). The MDS included diagnoses of cerebrovascular accident (CVA or stroke), anxiety, depression, disorientation, and mild cognitive impairment. Resident #3's Baseline Care Plan (BCP) dated 1/28/25 and locked at 1:36 PM reflected she had a confused cognition. The Interventions to address her cognition listed to redirect as she continued to say she is going home. The BCP reflected Resident #3 had intact skin with a goal to maintain her intact skin. During an interview on 3/3/25 at 4:25 PM Resident #3's Durable Power of Attorney (DPOA) confirmed the cat bit her as she grabbed it and placed it in the crate to take it to Resident #3 at the nursing facility. The DPOA described the cat as a devil cat. The DPOA indicated at the time she didn't know of the cat's vaccination status so she called the veterinarian and learned the cat didn't have their vaccines up to date. A faxed Physician Order form signed by the Physician on 1/29/25 reflected Resident #3 received six (6) marks (bites) on her left arm from her cat that measured 0.1 centimeters (cm) by (x) 0.1 cm. The Physician ordered the staff to cleaned the areas on the resident's left hand with normal saline, apply by Triple Antibiotic Ointment (TAO) and cover with a bandage two (2) times a day (BID) and as needed (PRN) until healed. A Weekly Skin Assessment form dated 2/3/25 locked at 2:01 PM indicated Resident #3 sustained a scab on her left palm. The Health Status Note dated 1/30/25 at 11:33 AM reflected the Physician wrote an order for Augmentin (antibiotic) 875 milligrams (mg) 1 tablet by mouth (po) two (2) times a day (BID) for seven (7) days due to a cat bite. The Health Status Note dated 1/30/25 at 1:01 PM identified the Physician wrote an order to discontinue the Augmentin and to start Clindamycin (antibiotic) 300 mg three times a day (TID) for 7 days. The Health Status Note dated 1/30/25 at 7:44 PM indicated Resident #3 took antibiotics for a urinary tract infection and a cat bite on her left palm and wrist. The area looked slightly pink, raised, with mild tenderness, and no warmth. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/27/25 at 3:00 PM the Administrator explained they told her the cat had their vaccinations up to date but after the phone call with the Veterinarian, they learned the last time the cat went to the office was back in 2012. During an interview on 2/27/25 at 1:07 PM Staff A, Licensed Practical Nurse (LPN), confirmed the DPOA brought in Resident #3's cat because she exhibited exit seeking behaviors and wanted to see her cat. So, they had the animal brought to the facility as a means of comfort her but she could only have it in her room. Staff A indicated around 4ish, maybe on the 29th a Certified Nurse Aide (CNA) who worked with Resident #3 came out of her room and said the cat growled at her. Staff A went to Resident #3's room and found the cat under the bed. Resident #3 entered the room and sat by her chair far away from the cat who hissed and attempted to claw Staff A. The cat sat/laid way back in the corner under the bed. Staff A asked Resident #3 to leave her room while she called the Office Manager and told her the cat hissed at Resident #3 and she couldn't get the cat removed so the Office Manager went to the room with a CNA and attempted to remove the cat. Resident #3 followed the staff members to her room as Staff A attempted to redirect her without success as she sat in her recliner. The staff moved Resident #3's bed out and had carrier right close. The cat darted out and ran to the side of the recliner as Resident #3 reached down and tried to console the cat as it bit her on the left wrist palm area, along the meaty section. Staff A assessed 5 6 teeth/puncture marks so she cleaned the area with soap and water, applied TAO, and covered the area with a dressing. When questioned if it hurt, Resident #3 said it stung a bit. Staff A described Resident #3 as upset about the cat so the staff member attempted to console her as she told her that current cat bite wasn't the first time. The staff removed the cat from the resident's room in the carrier crate and placed it in the nurse's station until the DPOA picked it up around 9 9:30 that night. Staff A asked the Office Manager about the cat's vaccination status and she told her the DPOA verbally described the cat as vaccinated. Staff A confirmed the facility didn't have written proof of vaccinations, just verbal. An email 3/4/25 at 12:50 PM revealed the Office Manager confirmed she called the DPOA and told her as long as the cat appeared friendly and had their vaccinations up to date, she didn't have a problem with the cat staying with Resident #3. When the staff told her the cat became aggressive, she came to the facility after hours and caught the cat. She called the DPOA and informed her the situation didn't work and she needed to remove the cat from the facility. During an interview on 2/27/25 at 1:50 PM Staff C, CNA, confirmed she peeked at Resident #3's cat positioned under the bed as it hissed at her, so she reported the situation to the Administrator and Office Manager. Staff C didn't know of the cat's vaccination status. During an interview on 2/27/25 at 2:04 PM Staff D, CNA, confirmed she worked the evening/night of 1/28/25 when Resident #3's cat came to the facility around 8 PM. When the cat arrived with a friend in a cage she leaned down to see the cat and it hissed at her. The friend told her it took her all day to catch the cat and the cat bit her. Staff D texted the Administrator and told her the cat would be an issue. Staff D confirmed she didn't know the cat's vaccination status. During an interview on 2/27/25 at 2:26 PM Staff E, CNA, confirmed she worked the evening/night the cat arrived. She explained what happened as the DPOA brought the cat to the facility in a cage. The DPOA literally told staff it took her five (5) hours to get the cat in the crate and it bit her. The cat stayed overnight in Resident #3's room but she never had any contact with the cat. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	According to an undated and untimed email, the Administrator indicated the facility didn't have a policy or procedure for pets/animals in the building.

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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. 25854 Based on resident interview, staff interview, Alarm Response Report forms, and facility policy review, the facility failed to answer a resident's call light in a timely manner and within the regulated 15-minute time-frame for 1 of 3 residents reviewed (Resident #6). The facility identified a census of 31 residents. Findings include. During an interview on 2/27/25 at 3:30 PM Resident #6 reported a couple weeks ago she timed the time it took for someone to answer her call light, it stay on from approximately 1:30 AM till 5:30 AM. At that time, she used her cell phone which gave her a feeling of anger and tired of being ignored. Resident #6 added other times she timed her call light on for 45 minutes on the 3rd shift which caused her to lose control of her stool (bowel movement) so she sat in her own poop, this caused her to feel unhappy because if the staff answered her light timely she wouldn't become incontinent. Resident #6 explained in October they left her in bed for 14 hours against her will because the facility failed to provide enough staff to get her up as she required three (3) staff assistance. Review of an Alarm Response Report form revealed Resident #6 had her call light on for over the allotted 15-minute time frame during the following dates and times: a. 2/17/25 at: - 5:49 PM for 36 minutes and 46 seconds b. 2/18/25 at: - 5:53 AM for 21 minutes and 22 seconds - 6:18 AM for 43 minutes and 2 seconds - 7:40 PM for 25 minutes and 30 seconds c. 2/19/25 at: - 1:09 PM for 32 minutes and 34 seconds - 6:08 PM for 1 hour, 22 minutes and 5 seconds - 8:08 PM for 1 hour 9 minutes and 59 seconds - 7:52 PM for 27 minutes and 3 seconds - 7:37 PM for 59 minutes and 18 seconds (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. 2/20/25 at: - 12:52 AM for 17 minutes and 46 seconds - 6:16 AM for 27 minutes and 7 seconds - 4:48 PM for 24 minutes and 28 seconds e. 2/21/25 at: - 1:19 PM for 16 minutes and 36 seconds - 6:59 PM for 1 hour 55 minutes and 50 seconds f. 2/22/25 at: - 6:06 PM for 22 minutes and 10 seconds - 6:20 PM for 21 minutes and 29 seconds During an interview on 2/27/25 at 12:13 PM Staff B, Licensed Practical Nurse (LPN), confirmed the facility's call light system didn't function at various times so they have given the residents bells. Staff B verified staff couldn't hear the bells especially when the facility only had one (1) nurse and 1 CNA on staff. Staff B indicated Resident #6 cried because the facility failed to provide enough staff to reposition her as she required 3 staff for assistance. During an interview on 2/27/25 at 1:07 PM Staff A, LPN, confirmed the facility call light systems didn't function for about 1 week. Staff A confirmed the staff couldn't hear the resident's call bells especially on the other end of the building and when they only had 1 nurse and 1 CNA on staff and/or they were in other resident rooms who required 2 3 staff assistance. During an interview on 2/27/25 at 1:50 PM Staff C, CNA, verified the call system didn't work for a week to a week and a half. The residents used bells during that time and/or just yelled from their rooms. Staff C confirmed the staff couldn't hear the bells and she didn't doubt resident call bells went unanswered within the allotted 15 minutes especially when the staff assisted residents who required 2 staff assistance. During an interview on 2/27/25 at 2:04 PM Staff D, CNA, confirmed the facility's call system work on and off so the residents used a bell when the call lights didn't function however the bells didn't work well. As you could imagine because the staff didn't know where they came from and they could only hear the bells if staff were located in a specific hallway. Also, the staff were supposed to walk the hallways every 15 minutes at 1st when the call system went out but when staff assisted residents in their rooms who required 2 staff assist they couldn't walk the hall every 15 minutes. The staff member added when the call light system worked, the staff couldn't answer the call lights within 15 minutes either. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/27/25 at 3:02 PM the Maintenance man confirmed in the past 2 months the facility replaced the communication box and they had 2 separate occasions during that same time frame, the call system didn't function. The facilities Answering the Call Light Policy dated 2001 directed assurance of timely call light responses to resident's requests and needs.