

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  11/14/2024
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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003</b></p> <p>Based on record review, policy review, and staff interview the facility failed to provide the resident or the resident's legal representative with a Skilled Nursing Advance Beneficiary Notice of Non-Coverage (SNF/ABN) and Notice of Medicare Non-Coverage (NOMNC) to document an appeal decision and the date of notification of Medicare non-coverage for 1 of 3 residents (Resident #10) sampled. The facility identified a census of 27 residents.</p> <p>Findings include:</p> <p>Resident #10's Electronic Census Record detailed the Resident admitted into Medicare Part A skilled services on 5/09/24 and discharged off on 8/16/24.</p> <p>The Admission Minimum Data Set (MDS) assessment dated [DATE] listed a diagnoses of septicemia, muscle weakness, dysphagia and urinary tract infection and detailed Resident #10 had received speech-language pathology treatment and physical therapy treatment. The MDS revealed a Brief Interview for Mental Status score of 3 out of 10 indicating severe cognitive impairment.</p> <p>A review of Resident #10's Progress Notes revealed the medical record lacked documentation the Resident or the Resident's legal representative had been notified of the discontinuation of Medicare Part A skilled services on 8/16/24.</p> <p>In an interview on 11/14/24 at 11:30 AM the Administrator reported Resident #10 did not have the notice given for Resident #10. She reported it should have been given but cannot find proof of it being done.</p> <p>Review of the facility policy for Skilled Services revised 6/10/24 documents the resident or representative will be notified 48 hours prior to terminations of skilled coverage and sign the form with date of notice.</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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>40907</p> <p>Based on interview and staff files review, the facility failed to do a background check on 1 of 5 staff reviewed. The employee file for Staff A, Certified Medication Aide (CMA) lacked a criminal background check. The facility reported a census of 27 residents.</p> <p>Findings include:</p> <p>A letter from the Chief Human Resources Officer (CHRO) and signed as accepted by Staff A on 12/5/22, documented that the CHRO was pleased to confirm an offer of conditional employment for the position of full time Certified Nurse Aide effective on 12/5/22.</p> <p>A review of Staff A's folder on 11/13/24, revealed that a background check was not in her file. It revealed a hire date of 12/5/22.</p> <p>On 11/13/24 at 1:17 PM, Staff B, Business Office Manager (BOM), stated the facility did not have a criminal background check for Staff A. This BOM stated she had a call out to the one Human Resource person who is left for the corporation, but the HR person is out on vacation until the 11/19/24. Staff B stated she did leave a message. This BOM stated she had an email out to 2 other staff as well. One who does payroll and one who is the benefits coordinator. The BOM stated she had looked through past emails and couldn't find anything regarding a background check for Staff A. She stated the corporation has been responsible for doing the background checks prior to hire in the past. Staff B stated she recently took over doing the background checks. When asked when she took the background checks over, she stated today.</p> <p>On 11/13/24 at 1:29 PM, the Payroll Director returned a call to Staff B and told her there was not a background check for Staff A.</p> <p>A Background Checks policy revised on 5/20/24, directed:</p> <p>To provide quality services and to ensure a safe working environment, every employee must successfully complete a background check before being granted regular employment.</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48003</p> <p>Based on clinical record review, policy review and staff interviews, the facility failed to complete a baseline care plan for 1 of 2 residents reviewed (Resident #27). The facility reported a census of 27 residents.</p> <p>Findings include:</p> <p>The Census tab in the Electronic Health Record (EHR) documented Resident #27 admitted on [DATE] and discharged on [DATE].</p> <p>Review of the Nursing Data Assessment for Resident # 27 completed on 10/22/24 documented the resident admitted to the facility post left knee replacement.</p> <p>Review of Resident #27's EHR lacked a completed baseline care plan.</p> <p>On 11/13/24 at 12:07 PM, the Administrator reported the baseline care plan for Resident #27 was not completed.</p> <p>During an interview on 11/13/24 at 12:16 PM, the Director of Nursing reported the baseline care plan should be completed within 72 hours of admission.</p> <p>Review of the facility policy for baseline care plans revised December 2016 documented a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>42441</p> <p>Based on clinical record review, resident interview, staff interviews and policy review, the facility failed to ensure residents had at least 2 baths/showers per week for 2 of 3 residents reviewed for bathing (Resident #4 and #6). The facility reported a census of 27 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) for Resident #6 revealed a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. The resident had a diagnosis of multiple sclerosis (an autoimmune disease where tissue hardens or stiffens)and required assistance from staff with bathing.</p> <p>The Care Plan revised 5/5/22 for Resident #6 revealed a focus area of an activity of daily living self care deficit related to limited mobility and directed staff to provide 2 staff participation with bathing.</p> <p>During an interview on 11/12/24 at 3:39 PM, Resident #6 revealed she was not consistently receiving showers as scheduled.</p> <p>Review of Electronic Health Record (EHR) for Resident #6 lacked documentation of showers/baths being offered or provided on the following dates:</p> <p>a. 10/4/24</p> <p>b.10/11/24</p> <p>c. 10/25/24</p> <p>Review of facility policy titled, Bath, Shower/Tub, revised February 2018 revealed the purpose of the procedures of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident ' s skin. The policy directed staff to document if the resident refused the shower/tub bath, the reason(s) why and the intervention taken, and to notify the supervisor if the resident refused the shower/tub bath.</p> <p>During an interview on 11/13/24 at 2:30 PM, the Director of Nursing (DON) revealed it is an expectation residents receive their showers the days they are due to be given. The DON further revealed if a resident does not receive their shower on the day it is scheduled, it would be an expectation the nurse, the DON or the Assistant Director of Nursing (ADON) would be notified.</p> <p>40907</p> <p>2. The Care Plan dated 2/24/23, directed that Resident #4 required 1 staff participation with bathing.</p> <p>Review of the EHR for Resident #6 lacked documentation of showers/baths being offered or provided on the following dates:</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a.10/17/24</p> <p>b.10/31/24</p> <p>c.11/7/24</p> <p>On 11/13/24 at 5:00 PM, the Assistant Director of Nursing (ADON) stated that they have been documenting showers and refusals of them on daily sheets. She said she was not able to find them and staff have been inconsistent about filling the information out. She doesn't know if they have been shredded or not. She will look for any further information the missing showers for Resident #4. She stated understanding that information was taken from documentation of transfers to tub/shower.</p> <p>The ADON did not provide any further information regarding missing documentation for showers.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>42441</p> <p>Based on clinical record review, resident interview and staff interview, the facility failed to ensure completion of physician ordered treatments for 1 of 2 residents (Resident #6). The facility reported a census of 27 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) for Resident #6 revealed a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. The resident had a diagnosis of multiple sclerosis (MS) (an autoimmune disease where tissue hardens or stiffens)and required assistance from staff with bathing.</p> <p>During an interview on 11/12/24 at 3:39 PM, Resident #6 revealed the dressing for her peripherally inserted central catheter (PICC) line was not consistently being completed as ordered by the physician.</p> <p>The Care Plan initiated 9/20/21 for Resident #6 revealed the resident had MS with a goal to remain free of complications or discomfort related to MS and directed staff to contact the provider right away if noticed signs or symptoms of PICC line complications. The Care Plan further directed staff to change the PICC line dressing using sterile technique weekly.</p> <p>Review of Physician Orders for Resident #6 revealed an order for a PICC line dressing change once a week, one time a day, every Sunday for PICC line care with a start date 7/21/24.</p> <p>Review of the October 2024 treatment administration record (TAR) for Resident #6 lacked documentation of the dressing being changed and lacked a rationale on 9/15/24 and 9/22/24.</p> <p>The facility lacked a policy specific to expectation physician orders are followed.</p> <p>During an interview on 11/14/24 at 8:20 AM the Assistant Director of Nursing revealed she would expect staff to document if a treatment was not completed as ordered in addition to documentation as to why the treatment was not completed as ordered.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40907</p> <p>Based on interviews, observations, and record review, the facility failed to do pre and post dialysis assessments for 1 of 1 resident who received hemodialysis (use of a machine to filter waste out of the kidneys) (Resident #24). The facility reported a census of 27 residents.</p> <p>Findings include:</p> <p>A Minimum Data Set (MDS) dated [DATE], documented Resident #24 admitted to the facility on [DATE]. A Brief Interview for Mental Status (BIMS), revealed a score of 9 out of 15, which indicated Resident #24 had moderate cognitive impairment. This MDS documented that diagnoses for Resident #24 included End Stage Renal Disease (ESRD). This MDS documented this resident received hemodialysis.</p> <p>A Care Plan initiated on 3/18/24, directed that Resident #24 needed hemodialysis related to renal failure, ESRD. It directed that Resident #24 would have immediate intervention should any signs or symptoms of complications from dialysis occur through the review date. It directed staff to encourage resident to go for the scheduled dialysis appointments on Tuesdays, Thursdays, and Saturdays (3 times a week).</p> <p>In an electronic record review on 11/13/24 at 9:28 AM, it was noted that pre and post dialysis assessments were not found in Resident #24's electronic health record. When the Administrator was asked where the assessments were found the Administrator stated she had her staff working on locating these assessments.</p> <p>On 11/13/24 at 3:26 PM, the Assistant Director of Nursing (ADON), stated all of the pre and post dialysis assessments were done on paper and none of them have been uploaded. When asked for the papers, the ADON stated she will have to find them.</p> <p>On 11/14/24 at 8:24 AM, the ADON stated that she was unable to locate pre and post dialysis assessments. She stated she could not find a substantial amount of assessments and the Director of Nursing (DON) was already working on a plan of correction. She stated their plan is to add the pre and post assessments on the MAR/TAR so they can ensure they get done. This ADON acknowledged knowing that the pre and post assessments should have been done.</p> <p>On 11/14/24 at 10:30 AM, the ADON provided 3 Dialysis Communication assessments dated 10/15/24, 10/26/24, and 11/2/24. The post assessments were not complete on these 3 assessments. The ADON stated she could not find any further documentation of assessments and acknowledged there should have been many more assessments. She provided a policy with the Dialysis Communication assessment attached on how to fill out the Dialysis Communication. The ADON stated that areas had been highlighted and written on before this survey and was to be used as a guide for nurses on what areas to fill out on the pre and post dialysis assessments.</p> <p>Provided by the ADON:</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Nursing Procedure Manual Shunt Care and Maintenance of an Internal Arteriovenous (AV) Access Device dated 1/2013 documented it's purpose was to provide safe and proper care to a resident/patient with an AV shunt for hemo-dialysis access. This policy had highlighted sentences and hand writing on it.</p> <p>The Dialysis Communication attached to the above Procedure also had highlighted sentences and hand writing on it.</p>		