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	12/22/2025

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on facility documents, schedule review, and staff interviews, the facility failed to provide a Registered Nurse (RN) in the facility for eight (8) consecutive hours per day as required by the Federal Regulations. In addition, the facility failed to have a full time Director of Nursing. The facility reported a census of 25 residents. Findings include:Review of the daily schedule for July 2025 lacked an RN on the 3rd, 14th, and 27th.The daily schedule for November 2025 lacked a RN for the 17th and 19th. On 12/17/25 at 2:55 PM the Interim Director of Nursing (DON) reported the facility did not have an RN on July 3rd, 14th 27th and November 17 and 19. The interim DON reported she knew of the lack of RN coverage, but she didn't become Interim until December 1, 2025.Review of the facility's New Hire and Termination List lacked a DON from 10/18/25 until 12/1/25.On 12/18/25 10:32 AM the Administrator reported the facility didn't have a DON from 10/18/25 until 12/1/25. They didn't have anyone in place at the time to cover.

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to notify the Resident or the resident's representative in advance of the risks verses benefits for psychotropic medication, the treatment alternatives or other options the representative preferred for 1 of 4 residents reviewed (Resident #1). The facility reported a census of 25 residents. Findings include:1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The MDS included diagnoses of schizophrenia (a chronic brain disorder that makes it difficult for a person to distinguish between what is real and what is not), dementia, diabetes, heart failure, anxiety, depression, and adult failure to thrive. Review of the Medication Administration Record (MAR) revealed the following orders: Paxil (a type of antidepressant that affects chemical in the brain to influence a person's mood, thinking, and behavior) 10 MG daily for depression starting on 12/16/23. Buspirone (an antianxiety medication that affects your brain to help balance your mood and reduce anxiety symptoms) 5 mg 2 times a day related to anxiety starting on 8/13/25. Lorazepam (an antianxiety medication that affects the brain and changes how you feel, think, and act) 0.25 mg 2 times a day related to anxiety starting on 8/13/25. Trazodone (an antidepressant medication that affects the brain and is used to treat mental health conditions like depression and anxiety) 25 Mg 3 times a day for depression starting on 9/2/25. Resident #1's Progress Notes from 12/1/23 to 12/15/25 lacked documentation of notifying them or their representative in advance of the risks versus benefits of Paxil, buspirone, lorazepam, and trazodone medications. In addition, the documentation lacked treatment alternatives or other options and let them choose the option they preferred prior to administering the medication on a routine basis as ordered. Resident #1's December 2025 Medication Administration Record (MAR) documented they received Paxil 16 times, buspirone 33 times, lorazepam 33 times, and trazodone 50 times. On 12/17/25 at 3:15 PM the interim Director of Nursing (DON) reported the facility didn't complete a consent form with Resident #1's Representative for Paxil, buspirone, lorazepam, or trazodone prior to starting the medications. The interim DON reported she would expect the facility staff to educate and document if the resident or resident representative received education about the medications risks vs. benefits. 2. Resident #19's MDS assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The MDS included diagnoses of cerebral infarction (a type of stroke where a blood clot blocks a brain artery, cutting off oxygen and nutrients, causing brain cells to die), neuralgia (a sharp, stabbing, or burning pain along a nerve's path, caused by nerve irritation, damage, or inflammation, often feeling like an electric shock and following the nerve's course), neuritis (a nerve inflammation, like a swollen, irritated wire in your body's electrical system, causing pain, tingling, numbness, or weakness in the area the nerve serves), (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aphasia (a communication problem that affects using and understanding language caused by brain injury), and dementia. Resident #19's December 2025 Medication Administration Record (MAR) listed an order for olanzapine (an antipsychotic that works in your brain and affects your mood, thoughts, and behavior) 5 mg daily for major depressive disorder starting on 7/4/25. The documentation indicated Resident #19 received olanzapine 17 times. Resident #19's Progress Notes from 7/1/25 to 12/15/25 lacked documentation of notifying them or their representative in advance of the risks versus benefits of the Olanzapine medication order. In addition, the documentation lacked treatment alternatives or other options and let them choose the option they preferred prior to administering the medication on a routine basis as ordered. On 12/17/25 at 3:15 PM the interim Director of Nursing (DON) reported the facility didn't complete a consent form with Resident #19 or their representative prior to starting the olanzapine medication. The interim DON reported the staff should speak with the family about risks vs benefits and document it. The undated facility policy titled Antipsychotic Medication Used lacked direction on notifying the resident or resident representative to educate and discuss the risks vs. benefits of antianxiety, antipsychotic, and antidepressant medications. In an interview on 12/22/25 at 3:42 PM with the Assistant Director of Nursing (ADON) explained the residents' electronic health record should include the medications consents under Assessments. They were working on getting them all in the system.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to document the release of a seat belt every 2 hours, failed to obtain an informed consent for the use of a seat belt in a wheel chair from the resident's representative in advance of potential risks and benefits of all options under consideration including using a restraint, not using a restraint, and alternatives to restraint use for 1 of 1 residents reviewed (Resident #8). The facility reported a census of 25 residents. Findings include: Resident #8's Care Area Assessment Worksheet dated 2/12/25 listed them as severely impaired with making decisions regarding tasks of daily life. They had difficulty making themselves understood or understanding others. Resident #8 had a functional limitation in range of motion. They had a seizure disorder. Resident #8 took antianxiety medications. The progress noted revealed the following:a. On 7/29/25 at 8:51 AM to the physician asking for an order to release the resident's seatbelt when he is in his w/c.b. On 7/29/25 at 13:36 a fax was received back regarding seatbelt ok The Care Plan Problem revised 11/14/24 indicated Resident #8 had a self-care deficit as evidenced by the need to have assistance with activities of daily living (ADLs), impaired balance during transitions requiring assistance and/or incontinence. The Interventions directed the following:a. Revised 5/8/25: When in wheelchair reposition Resident #8 and release his seatbelt every 2 hours.b. 11/14/24: Resident #8 didn't ambulate (walk) and used a reclining wheelchair that staff propel. Release his seat belt when in the wheelchair every 2 hours. Review of the Electronic Health Records (EHR) orders revealed the following orders:a. Started 7/29/25 and discontinued 12/16/25: Release seatbelt with no directions specified.b. Started 4/25/25 and discontinued 7/13/25: When in the wheelchair, release wheelchair every shift for protocol seatbelt and reposition resident every 2 hours with directions every shift for protocol. The General Progress Note dated 7/29/25 indicated the facility asked Resident #8's primary care provider (PCP) for a seatbelt while in the wheelchair. The General Progress Note dated 7/29/25 at 1:36 PM reflected the PCP replied okay to the use of seatbelt. Resident #8's N Restraint/Medical Device Comprehensive/Quarterly assessment dated [DATE] at 7:24 AM documented the use of a seatbelt on the wheelchair as a physical restraint/non-restraint. Previous attempts to use a less restrictive device included medication adjustments, Occupational Therapy, and a specialized wheelchair. The benefits of the restraint/nonrestraint device included:Prevent Injury to themselvesEnhances functional status/abilityProvides medically necessary proceduresMaintains correct positionReduce risk of fallingMaintain integrity of feeding tube.Resident #8 didn't have complications with the use of the seatbelt. The recommendations for restraint/nonrestraint reduction decision listed the seatbelt as a restraint. Resident #8's December 2025 Treatment Administration Record (TAR) included an order dated 12/16/25 to release his seatbelt when in wheelchair every 2 hours, related to epilepsy. The facility lacked any documentation of family or resident education or consent for seat belt orders from 4/25/25 through 12/18/25. On 12/18/25 at 8:04 AM observed Resident #8 resting quietly in his bed. On 12/18/25 at 10:14 AM witnessed Resident #8 sitting in his wheelchair wearing his seatbelt, smiling and watching TV in the lounge area. On 12/17/25 at 3:15 PM the interim Director of Nursing (DON) reported they didn't have an informed consent for the use of the seat belt. The interim DON stated she would expect to have an informed consent for the use of the seat belt. During an interview on 12/22/25 at 4:00 PM the Assistant Director of Nursing (ADON). The ADON revealed that she was not aware of any consents for the use of the seat belt. The ADON stated she would expect the facility to obtain a consent for the use of a seat belt.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to complete Minimum Data Set (MDS) assessment and Care Area Assessment (CAA) worksheet for pressure ulcers for 1 of 1 resident reviewed (Resident #4). In addition, the facility failed to complete 1 of 2 residents CAA worksheet for Nutrition (Resident #24). The facility reported a census of 25 residents. Findings include: 1. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 15, indicating no cognitive impairment. The MDS documented 2 unstageable pressure ulcers (a severe skin wound where the base is hidden by dead tissue, making its true depth and severity impossible to determine until the dead tissue is removed). The MDS listed the 2 unstageable pressure ulcers as not present during her admission to the facility and were acquired during her stay at the facility. Review of the MDS Care Area Assessment (CAA) worksheet dated 9/28/25 related to pressure ulcers revealed the facility MDS Coordinator checked the box Resident #4 pressure ulcer areas needed implemented on the Care Plan, but failed to complete the section that describes the impact it will have, rationale for care planning, risk factors, and if a referral to other health professionals would be needed. In an interview on 12/18/25 at 11:45 AM Resident #4 explained she didn?t have new pressure ulcers form since her admission to the facility. In an interview on 12/22/25 at 12:13 PM Staff C, Registered Nurse (RN), described Resident #4's pressure ulcers as getting better. She added Resident #4 didn't have a new pressure ulcer since her admission to the facility. She reported the MDS Coordinator worked offsite and not at the facility. 2. Resident #24's MDS assessment dated [DATE] identified a BIMS score of 3, indicating severe cognitive impairment. The MDS included diagnoses of Parkinson's, dehydration, and depression. The MDS listed a weight of 230 pounds (lbs.). Review of the MDS Care Area Assessment (CAA) worksheet dated 10/3/25 related to nutritional status revealed the facility MDS Coordinator indicated nutritional status should be addressed on the Care Plan, but failed to complete the section that described the impact it will have, rationale for care planning, risk factors, and if a referral to other health professionals would be needed. The Weight / Skin Summary Note dated 12/5/25 at 11:47 AM documented a meeting with the Assistant Director of Nursing and the Dietician. The not listed his weight on 12/2/25 as 190.4 lbs. The nurse reflected he lost 9% of his body weight in 1 month, admitted to hospice level of care, ate very poorly, and refused many meals. Recommend to have provider document the weight loss as unavoidable. Resident #24's MDS assessment dated [DATE] documented a weight of 190 lbs., not on a physician prescribed weight-loss regimen. The MDS indicated he received Hospice level of care. In an interview on 12/22/25 at 3:42 PM the Assistant Director of Nursing (ADON) reported the facility's company started an internal audit for the CAA's on 12/19/25 after learning of the incomplete worksheets. An unsuccessful attempt to contact the facility's MDS Coordinator occurred on 12/23/25 at 4:03 PM. As of 12/29/25, no return call received.

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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** Based on clinical record review, staff interview, and Preadmission Screening and Resident Review (PASRR) manual, the facility failed to accurately code the PASRR Level ll on the Minimum Data Set (MDS) assessment for 1 of 2 residents with a PASRR Level II (Resident #2). In addition, the facility failed to accurately code pressure ulcers were not acquired at the facility for 1 of 1 resident with pressure ulcers (Resident #4). The facility reported a census of 25. Findings include:1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] reflected they didn't have a state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. The MDS identified a Brief Interview of Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The MDS included diagnoses of schizophrenia (a chronic brain disorder that makes it difficult for a person to distinguish between what is real and what is not), anxiety, depression, dementia, neurocognitive disorder with Lewy bodies (a disease process that scrambles the brain's ability to think, move, and function correctly), and heart failure. Resident #2's Level ll PASRR dated 9/18/25 indicated the need for ongoing psychiatric medication management by a psychiatrist or psychiatric Advanced Registered Nurse Practitioner (ARNP) to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate the ongoing need for additional behavioral health services. Resident #2's PASSAR dated 9/18/25 identified services required based on the diagnosis of schizoaffective disorder, depressive. On 12/18/25 at 8:44 AM the interim Director of Nursing (DON) stated the MDS didn't accurately reflect the PASSAR level ll status and she would expect the PASSR to be coded correctly on the MDS. 2. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 15, indicating no cognitive impairment. The MDS documented 2 unstageable pressure ulcers (a severe skin wound where the base is hidden by dead tissue, making its true depth and severity impossible to determine until the dead tissue is removed). The MDS listed the 2 unstageable pressure ulcers as not present during her admission to the facility and were acquired during her stay at the facility. Review of the MDS Care Area Assessment (CAA) worksheet dated 9/28/25 related to pressure ulcers revealed the facility MDS Coordinator checked the box Resident #4 pressure ulcer areas needed implemented on the Care Plan, but failed to complete the section that describes the impact it will have, rationale for care planning, risk factors, and if a referral to other health professionals would be needed. In an interview on 12/18/25 at 11:45 AM Resident #4 explained she didn't have new pressure ulcers form since her admission to the facility. In an interview on 12/22/25 at 12:13 PM Staff C, Registered Nurse (RN), described Resident #4's pressure ulcers as getting better. She added Resident #4 didn't have a new pressure ulcer since her admission to the facility. She reported the MDS Coordinator worked offsite and not at the facility. In an interview on 12/22/25 at 3:42 PM with the Assistant Director of Nursing (ADON) reported Resident #4 didn't acquire new pressure ulcers at the facility and they were coded inaccurately. The ADON added Resident #4 had the 2 unstageable pressure ulcers present on Admission. Resident #4 Progress Notes from 9/24/25 to 9/28/25 lacked documentation of new acquired pressure ulcers during her stay at the facility.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy and staff interview, policy review, the facility failed to incorporate the recommendation from the PASARR level ll determination and the evaluation report into the resident's assessment and care planning for 1 of 2 residents with new mental health diagnoses (Resident #2). Pre-admission Screening and Resident Review (PASRR) Level II (a in-depth federal assessment for individuals applying to or residing in Medicaid-certified nursing facilities, determining if they have a Serious Mental Illness or Intellectual Disability/Related Condition and need specialized services, this ensures they aren't inappropriately placed and receive care in the most integrated setting possible, involving comprehensive evaluations by mental health/disability experts). The facility reported a census of 25. Findings include: Resident #2's Minimum Data Set (MDS) assessment dated [DATE] reflected they didn't have a state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. The MDS identified a Brief Interview of Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The MDS included diagnoses of schizophrenia (a chronic brain disorder that makes it difficult for a person to distinguish between what is real and what is not), anxiety, depression, dementia, neurocognitive disorder with Lewy bodies (a disease process that scrambles the brain's ability to think, move, and function correctly), and heart failure. Resident #2's PASARR dated 9/18/25 identified services required based on the diagnosis of schizoaffective disorder, depressive. Resident #2's clinical record lacked PASARR level ll. On 12/18/25 at 8:44 AM the interim Director of Nursing (DON) explained the PASARR level ll didn't get correctly coded on the MDS. The interim DON reported she would expect the PASARR level ll to be coded correctly on the MDS. In an interview on 12/22/25 at 4:05 PM the Social Worker (SW) admitted she didn't know until the previous week on 12/17/25 or 12/18/25 the PASRR recommendations listed on Resident #2 PASRR Level II need implemented into his Care Plan. In addition, she knew he saw psychiatry services. She added the facility hadn't trained her since she became the SW over a year ago, which recommendations need to be on the Care Plan for PASRR Level II residents.

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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** Based on record review, staff interview and policy review the facility failed to implement interventions for 1 of 1 resident with unstageable pressure ulcers. The facility reported a census of 25 residents. Findings include: 1. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 15, indicating no cognitive impairment. The MDS documented 2 unstageable pressure ulcers (a severe skin wound where the base is hidden by dead tissue, making its true depth and severity impossible to determine until the dead tissue is removed). The MDS listed the 2 unstageable pressure ulcers as not present during her admission to the facility and were acquired during her stay at the facility. The Care Plan Problem revised 12/12/25 indicated Resident #4 admitted with pressure areas to her coccyx (area in the lower back just above the buttock), left ischium (hip), and right ischium. In addition, she had pressure area to her left lateral (side) ankle, right lateral ankle, and both sides of her coccyx. The Interventions lacked resident specific interventions to promote and prevent further deterioration of pressure ulcer sites, such as but not limited to; type of treatments or medications and supplies; residents input for when treatments should be completed, pain interventions for wound care, and external wound care providers interventions. In an interview with the Assistant Director of Nursing (ADON) on 12/22/25 at 3:42 PM reported the facility implemented a comprehensive Care Plan for Resident #4. The Care Plan included interventions for an alternating air pressure mattress and repositioning every 2 hours. Review of the facility's Pressure Ulcers/Injury Overview policy dated 2001 lacked instructions on Care Planning and completion of the facility's process to complete assessments.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observations, facility document review and staff interviews, the facility failed to post the daily staff posting with the census and facility name. The facility reported a census of 25 residents. Findings include:An observation on 12/15/25 at 3:17 PM observed the facility didn't have the daily staff posting didn't contain the resident census or the facility name. An observation on 12/16/25 at 3:20 PM observed the facility didn't have the daily staff posting didn't contain the resident census or the facility name. An observation on 12/17/25 at 3:42 PM observed the facility didn't have the daily staff posting didn't contain the resident census or the facility name. During an interview on 12/18/25 11:41 AM, the Administrator reported the overnight nurses did the daily staff postings. She reported the nurses fill out the nurses and CNA number of staff and hours totaled each shift. She reported she didn't believe the staff put the census of it. On 12/18/25 at 11:44 AM observed with the Administrator the daily staff posting didn't contain the resident census or the facility name.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on facility record review, staff interview and policy review, the facility failed to have the minimum required members at the Quality Assessment and Assurance (QAA) meetings to identify issues with respect to which quality assessment and assurance activities are necessary. The facility reported a census of 25 residents.Findings include:Review of the facility QAA sign in sheets revealed the facility didn't have the Infection Preventionist present at the March, May, August or November quarterly meetings. In addition, the facility didn't have the Director of Nursing (DON) present at the May or November quarterly meetings. The Administrator didn't attend the August quarterly meeting. On 12/17/25 at 10:30 AM the Administrator reported she didn't know the facility didn't have all required staff at the QAA meetings. She reported the facility struggled with staffing. Review of the facility's Quality Assurance and Performance Improvement (QAPI) Committee dated July 2016 lacked direction on the required amount needed at the QAA meetings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review, and policy review the facility failed to use enhanced barrier precautions (EBP infection control measures, requiring healthcare workers to wear gowns and gloves for high-contact care) when providing routine catheter care for 1 of 1 resident reviewed (Resident #9). The facility reported a census of 25 residents. Findings include:Resident #9's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 15, indicating no cognitive impairment. The MDS listed her as dependent (staff does all the effort) on staff for toileting hygiene (perineal hygiene). The MDS documented she used a catheter. The MDS included a diagnosis of neurogenic bladder (a condition where nerve damage to the brain, spinal cord, or peripheral nerves disrupts the signals controlling bladder function, leading to loss of control, incontinence, urinary retention, or incomplete emptying) Resident #9's Order Summary Report dated 7/14/25 documented an order to change her catheter every 30 days and clean around the suprapubic catheter (a tube inserted through a small cut in your lower belly into the bladder to drain urine) every day. An observation on 12/16/25 at 10:47 AM of Resident #9 lying in her bed in her room with her catheter bag (a bag that collects urine and is connected by a tube to the catheter) clipped to the bed. The tube hung below the catheter bag causing urine to backflow (when urine flows backward from the drainage bag into the bladder, increasing infection risk (UTI) by allowing bacteria to travel up). The room smelled throughout of a strong pungent urine odor. On 12/18/25 at 9:31 AM observed Resident #9's catheter tube below the catheter bag causing the urine to backflow. On 12/22/25 at 2:13 PM observed Staff B, Certified Nurse Aide (CNA), apply gloves and perform routine emptying of the catheter bag into a graduate (container used to measure output of urine). Staff B changed their gloves, lifted the blanket up, and removed Resident #9's briefs to access her suprapubic catheter site to start to clean the area. She picked up a wet washcloth from a water basin and applied foam soap to the washcloth, then proceeded to rub the washcloth back and forth on her skin around the suprapubic site 3 to 5 times with the same part of the washcloth. Staff B grabbed the catheter tubing and washed down the tubing and back up with the same location of the washcloth. With the same gloves, Staff B grabbed a new wet washcloth from the water basin and wiped the washed sites. Without changing their gloves or completing hand hygiene, Staff B put back on Resident #9's brief and covered her up with her blanket. In an interview on 12/22/25 at 2:24 PM Staff B confirmed she should have worn a gown when she emptied Resident #9's catheter bag and cleaned around the suprapubic catheter site. In an interview on 12/22/25 at 3:42 PM the Assistant Director of Nursing (ADON) explained the staff should wear EBP protective equipment, gown, and gloves when providing catheter care. In addition, she added the staff should change the site they wash and gloves after cleansing the site prior to using the rinsing the wash cloth. Review of the facility's Catheter Care policy dated 4/3/25 instructed the following: Ensure drainage bag is located below the level of the bladder to discourage backflow of urine. For females, perform hand hygiene, apply gloves, wipe from front to back with a clean cloth moistened with water and perineal cleaner (soap). Use a new part of the cloth or different cloth for each side. With a new moistened cloth, starting at the urinary meatus moving out, wipe the catheter making sure to hold the catheter in place so as to not pull on the catheter. Dry area with towel. Bag and gather all supplies used, discarding disposable items in the trash can. Assist resident to a comfortable, appropriate position. Ensure their call light is within reach. Return room back to the original order. Perform hand hygiene.

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	12/22/2025

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

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on facility policy and staff interviews, the facility failed to have a qualified Infection Preventionist to monitor and provide oversight to the facility's infection prevention program. The facility reported a census of 25 residents.Findings include: On 12/15/25 at 10:10 AM, the Administrator reported the facility didn't have a qualified Infection Preventionist for the building. The Administrator reported the Assistant Director of Nursing (ADON) started taking the classes but had not completed them. On 12/18/25 at 10:35 the ADON reported she is currently taking the classes to become a qualified Infection Preventionist. The facility policy titled Infection Prevention and Control Program documents the program is coordinated and overseen by an Infection Prevention Specialist.

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review and staff interviews, the facility failed to provide pneumococcal vaccine as requested for 2 of 5 residents reviewed (Resident #4 and #15). The facility reported a census of 25 residents.Findings include: 1. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated Resident #4 didn't receive a pneumococcal vaccine due to the facility not offering the vaccine. A Pneumococcal Conjugate Informed Consent form dated 9/24/25, signed by the Resident #4, indicated that she received information and gave consent to receive the vaccine. Resident #4's Electronic Health Record (EHR) lacked documentation of receiving the pneumococcal vaccine. On 12/17/25 at 2:58 PM the interim Director of Nursing (DON) reported Resident #4 didn't get the pneumococcal vaccine as consented. The undated facility policy titled Infection Prevention and Control Program documented to try and help prevent the spread of infections to immunize residents. 2. Resident #15's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated Resident #15 didn't receive a pneumococcal vaccine due to the facility not offering the vaccine. A Pneumococcal Immunization Informed Consent form dated 6/6/25, signed by Resident #15's Representative, indicated they received information and gave consent for Resident #15 receive the vaccine. Resident #15's Electronic Health Record (EHR) lacked documentation of receiving the pneumococcal vaccine. On 12/17/25 at 2:58 PM the interim Director of Nursing (DON) reported Resident #15 didn't get the pneumococcal vaccine as consented.