STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165180	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odebolt Specialty Care	801 South Des Moines Street Odebolt, IA 51458

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, Center for Medicare and Medicaid (CMS) Long Term Care (LTC) Facility Resident Assessment Instrument (RAI) User Manual and staff interview the facility failed to complete a Minimum Data Set (MDS) Significant Change in Condition Assessment (SCSA) for 1 of 12 residents reviewed (Resident #3). The facility reported a census of 29 residents. Findings include: Resident #3's Quarterly MDS dated [DATE] revealed Resident #3 required substantial /maximal assistance (helper does more than half the effort. Helper lifts or holds the trunk or limbs and provides more than half the effort) with upper and lower body dressing, partial/moderate assistance (helper does less than half the effort. Helper lifts, holds or supports the trunk or limbs but provides less than half the effort) with bed mobility and with all transfers. The Progress Note dated 9/30/25 documented the Nurse Practitioner (NP) evaluated Resident #3 due to complaints of right heel pain. Resident #3 reported when she was getting up to the bathroom she heard and felt a pop. New orders were received to obtain a 2 view x-ray of the right foot due to pain. The Progress Note dated 9/30/25 at 8:46 AM documented Resident #3 had a fall in her room with a suspected injury to her left arm. Resident #3 was sent to the hospital by ambulance. The Progress Note dated 10/1/25 titled Nursing/Therapy Communication revealed Resident #3 had a fall with fracture on 9/30/25. The note documented Resident #3 would need re-evaluation when she returns for falls and transfers due to a fractured foot and humerus. The Progress Note dated 10/16/25 documented Resident #3 returned from the hospital for skilled care. Resident #3 required a mechanical lift for transfers and moderate assist for turning. The Progress Note dated 10/20/25 documented Resident #3 was seen by NP for a hospital follow up. The note revealed prior to hospitalization, Resident #3 had felt and heard a pop in her right heel. An x-ray was ordered and while waiting to get the x-ray, Resident #3 suffered a fall and fractured her left humerus. She was evaluated and treated in the emergency room, where the x-ray of her right foot showed a right heel fracture. Resident #3 underwent an open reduction and internal fixation (ORIF) of the left humerus and excision of the calcaneus fracture fragment and repair of Achilles tendon. Resident #3's Quarterly MDS dated [DATE] revealed Resident #3 was dependent (helper does all the effort. The resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers are required for the resident to complete the activity) on staff to complete upper and lower body dressing, required substantial/maximal assistance with bed mobility and was dependent on staff for all transfers. Resident #3's Quarterly MDS dated [DATE] revealed Resident #3 was dependent on staff to complete lower body dressing, required substantial/maximal assistance with bed mobility and was dependent on staff for sit to stand transfers and toileting transfers. The Care Plan with a target date of 6/3/26 revealed Resident #3 required substantial assistance with a mechanical stand for transfers/ambulation, substantial/maximal assistance with bed mobility and was dependent on staff for toileting. Review of the Resident #3 MDS Tracking page revealed Resident #3 had not been set up for a Significant Change in Status MDS assessment from October 2025 to March 2026. On 3/11/26 at 9 AM, the MDS Coordinator reported she had not considered completing a Significant Change MDS related to activity of daily living (ADL) declines. She said she usually would complete an Significant Change MDS when a resident started hospice services (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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or there was an overall decline. The MDS Coordinator reported she had a lack of knowledge or education regarding when a Significant Change MDS was required.On 3/11/26 at 2:00 PM, the MDS Coordinator acknowledged a Significant Change MDS should have been completed for Resident #3. She said she discussed it with the Regional Reimbursement Specialist and received education regarding what would qualify for a Significant Change MDS. On 3/11/26 at 3:15 PM, the Corporate Nurse reported the facility did not have a policy related to Significant Change MDS. She said the facility follows the RAI manual.The CMS LTC RAI 3.0 User's Manual, Version 1.20.1 October 2025, Chapter 2 under Significant Change in Status Assessment (SCSA) directs the SCSA is a comprehensive assessment that must be completed when the interdisciplinary team (IDT) has determined that a resident meets the significant change guidelines for either a major improvement or decline. A Significant Change is defined as a major decline or improvement in a resident's status that:1. Will not normally resolve itself without interventions by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting. 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan.

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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 interviews, and the Center for Medicare and Medicaid (CMS) Long Term Care (LTC) Facility Resident Assessment Instrument (RAI) User Manual the facility failed to represent an accurate picture of the resident's status during the observation period of the Minimum Data Set (MDS) by not accurately recording medication use for 3 of 5 residents reviewed (Resident #2, #3, #1). The facility reported a census of 29 residents. Findings include: 1. Resident #2's MDS dated [DATE] revealed diagnoses of non-alzheimer's dementia and anxiety disorder. The MDS further revealed Resident #2 did not receive antianxiety medication during the 7 day look back period. A Physician Order dated 4/26/24 directed staff to administer Lorazepam (antianxiety medication) 0.25 milligrams (mg) two times a day for generalized anxiety disorder. Review of the December 2025 Medication Administration Record (MAR) revealed Resident #2 received Lorazepam twice a day during the 7 day look back period. On 3/10/26 at 12:22 PM, the MDS Coordinator verified the antianxiety medication was not coded on the recent MDS. She reported the MDS was corrected/modified and would be transmitted. 2. Resident #3's MDS dated [DATE] and 2/23/26 revealed diagnoses of coronary artery disease, hypertension, and a fracture of the left humerus. Both MDSs documented Resident #3 received an anticoagulation medication during the 7 day look back period. Review of the October and November 2025 MAR revealed a Physician Order for Rivaroxaban (anticoagulant medication)10 mg one tablet one time a day to prevent blood clots for 30 days. The Physician Order had a start date of 10/16/25. The November MAR indicated the last dose of the anticoagulant medication was given on 11/14/25. Review of Resident #3's clinical record revealed no orders for an anticoagulant medication from November 15, 2025 to March 2026. On 3/10/26 at 10:00 AM, the MDS Coordinator acknowledged Resident #3 was not taking an anticoagulant medication and both MDS were not coded corrected. On 3/10/26 at 10:39 AM, the MDS Coordinator reported both MDS were modified/corrected and the anticoagulant medication was removed from the care plan. On 3/10/26 at 1:05 PM, the MDS Coordinator reported the facility follows the RAI manual and does not have a specific policy regarding accurately coding the MDS. The CMS LTC RAI 3.0 User's Manual, Version 1.20.1 October 2025, Chapter 3 Section N- Medications directed to code all high-risk drug class medications according to their pharmacological classification, not how they are being used. The RAI manual directed to check if the resident was taking any medications by pharmacological classification during the 7 day observation period or since admission/entry or reentry if less than 7 days and code in column one. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #1's MDS dated [DATE] revealed diagnoses of pneumonia, anxiety disorder, and schizophrenia. The MDS documented Resident #1 received an anticoagulation medication during the 7 day look back period. Review of Resident #1's clinical record revealed no orders for an anticoagulant medication from February 24th, 2026 to February 28th, 2026.

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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 observations, clinical record review, staff interviews, and policy review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 2 of 2 residents reviewed for (Resident #19 and Resident #28). The facility reported a census of 29 residents.Findings include: 1.Resident #28's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS identified Resident #28 was partial/moderate assistance with bed mobility, and transfers. Resident #28's MDS included diagnoses of depression, diabetes mellitus, and neurogenic bladder. A Physician Order dated 2/25/26 directed staff to apply Calmoseptine to buttocks topically twice a day. On 3/11/26 at 9:00 am observed Staff A, Licensed Practical Nurse (LPN) provided treatments to Resident #28's buttocks and abdomen area. When entering Resident #28's room, observed Staff A had a gown and a pair of gloves on. Staff A was holding a medicine cup of cream with her left hand. While waiting for the certified nursing assistants (CNA) to complete pericare, Staff A's walkie talkie requested her presence to another room, Staff A with her right hand proceeded to move her gown out of the way and answer the walkie talkie, then returned the walkie talkie to her uniform under her gown. Staff A with the dirty gloved right hand that had touched the walkie talkie, gown and uniform proceeded to complete the treatment to Resident #28's buttocks. On 3/11/26 at 1:00 pm, Staff A verified she had touched the walkie talkie with her gloved hand prior to performing the treatment. She acknowledged she should have changed her gloves and completed hand hygiene before completing the treatment. On 3/11/26 at 3:00 p.m. with the MDS Coordinator stated the expectation for the staff is to change gloves and do hand hygiene between gloving. The facility policy named Personal Protective Equipment - Using Gloves dated 9/2010 revealed staff are to change their gloves: When touching excretions, secretions, blood, body fluids, mucous membranes or non-intact skin; When the employee's hands have any cuts, scrapes, wounds, chapped skin, dermatitis, etc.; When cleaning up spills or splashes of blood or body fluids; When cleaning potentially contaminated items; and Whenever in doubt. 2. Resident #19's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 07, indicating moderately impaired cognition. The MDS identified Resident #19 was independent with bed mobility, transfers and ambulation. Resident #19's MDS included diagnoses of chronic cholecystitis (swelling and irritation of the gall bladder), diabetes (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mellitus, hyperlipidemia and renal disease (kidney). The Care Plan with a target date of 5/13/26 revealed Resident #19 had a biliary tube (thin, flexible tube that collects extra bile from the bile ducts). A Physician Order dated 12/4/25 directed staff to flush the biliary tube with 10 milliliters (ml) of normal saline daily. On 3/11/26 at 9:27 AM observed Staff A, Licensed Practical Nurse (LPN) flush Resident #19's biliary tube. When entering Resident #19's room, observed Staff A had a gown and a pair of gloves on. Staff A was holding a walkie talkie with her right hand. She then proceeded to move her gown out of the way with her left hand and put the walkie talkie on her uniform with her right hand. Staff A with the dirty gloves that had touched the walkie talkie, gown and uniform proceeded to complete the biliary tube flush. Staff A took the biliary tube cap off, cleansed the end of the tube with an alcohol swab, attached the syringe with normal saline, flushed the tube and then cleansed the end of the tube with another alcohol swab. On 3/11/26 at 9:42 AM, Staff A verified she had touched the walkie talkie with her gloved hand prior to performing the treatment. She acknowledged she should have changed her gloves and completed hand hygiene before completing the flush.