

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165274	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/26/2025
NAME OF PROVIDER OR SUPPLIER  Northern Mahaska Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE  2401 Crestview Drive Oskaloosa, IA 52577	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>48888</p> <p>Based on staff interviews, clinical record review, and review of facility provided documents, the facility failed to report an allegation of abuse timely, within the required two hours, of staff becoming aware that allegation existed for 1 of 3 residents (Resident #1) reviewed for resident's rights and dignity.</p> <p>Findings include:</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 1/14/25, revealed Resident #1 admitted to facility on 1/08/25, and had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. Resident #1 diagnoses included Bipolar Disorder, End Stage Renal Disease (ESRD), and atrial fibrillation.</p> <p>The Care Plan Kardex, a document Direct Care Staff use to direct resident care needs, dated 2/25/25, revealed Resident #1 required the presence of 2 staff for when performing care related to accusations of abuse and resident behaviors during cares.</p> <p>On 2/26/25 at 12:18 PM, Staff A, Certified Nursing Assistant (CNA), confirmed working the day shift with Resident #1 on 1/16/25. Staff A reported on 1/16/25, sometime after lunch and before Resident #1 was to leave for an appointment, Staff A answered Resident #1's call light and Resident #1 was found sitting in recliner, crying, and stated to Staff A, she had never been treated so terribly. Resident #1 had informed Staff A, that she threw something onto Resident #1 and left. Staff A recalled that resident had sat in recliner with blanket on lap, socks in her hands, and cloth bag next to recliner. Staff A stated Staff C, facility's Van Driver, had also been present in Resident #1's room during accusation and Staff C went to tell Director of Nursing (DON) that Resident #1 had been upset and was refusing to go to appointment, while Staff A stayed with Resident #1. Staff A recalled that Staff B, CNA, had also worked with Resident #1 on 1/16/25 and was the last staff known to go into Resident #1's room before finding resident upset.</p> <p>(continued on next page)</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/26/25 at 9:50 AM, Staff C, facility Van Driver, recalled that Resident #1 had an afternoon appointment on 1/16/25 and when he went to Resident #1's room to see if she was ready, Resident #1 had been upset and crying. Staff C notified that Staff A had also been present in room when Resident #1 stated she had never been treated that way and commented that something was thrown at her. Staff C recalled Resident #1 had sat in recliner with blanket across lap at the time with socks in her hands. Staff C stated he went to go notify DON of situation as Resident #1 was upset and refusing to go to appointment. Staff C reported that Resident #1 did go to appointment via facility van, accompanied by a family member, and continued to be upset, reporting the allegation to family member. Staff C stated he texted the DON in response to resident and family member concern with situation.</p> <p>On 2/26/25 at 1:30 PM, Director of Nursing (DON) recalled on 1/16/25, Staff C, facility van driver had come to her to report Resident #1 upset, crying, and not wanting to go to appointment. DON stated she went to Resident #1's room to speak to her about why she was upset, thought everything was okay, and Resident #1 was going to go to her appointment. DON confirmed receiving a text notification from Staff C, while Resident #1 was out to appointment, that Resident #1 and a family member had concerns about the situation. DON stated when Resident #1 returned, she spoke with family member, and would start investigation into the concern. DON reported that Staff B had been suspended on 1/17/25 pending investigation, due to Resident #1's allegation, Staff B working with Resident #1, and Resident #1 denying that Staff A upset her. DON stated she did not report an allegation of abuse to the State Department of Inspections, Appeals, and Licensing (DIAL) on 1/16/25 or 1/17/25 due to initially thinking situation was more of a customer service concern until more information was collected.</p> <p>On 2/26/25 at 2:05 PM, Facility Administrator, stated on 1/18/25, she received an email related to Resident #1's allegation of abuse and in response, Administrator called the facility to collect staff statements, called and spoke to Resident #1 and Resident #1's family, present at facility, and submitted a self reported incident for Resident #1 allegation of abuse. Administrator recalled that Resident #1 said something was thrown at her but the item thrown kept changing and Resident #1 had not been able to name or describe the accused staff member. Administrator revealed Staff B had been suspended on 1/17/25, pending investigation into allegation, as it was determined that Staff B had been in Resident #1's room just before allegation was made. Facility Administrator stated facility policy directs for any allegation of abuse to be reported to the State Agency within 2 hours of knowledge of the allegation and confirmed that staff had knowledge of allegation of abuse on 1/16/25, which had not been reported until 1/18/25.</p> <p>The facility provided Staff B, Certified Nursing Assistant (CNA) statement which informed that on 1/16/25 Staff B took Resident #1 to her room, got her in recliner and walked out. Staff B claimed that Staff C informed her that Resident #1 had an appointment, so she went back to Resident #1's room but Staff A was already there so let Staff A get her ready. Staff B's statement claimed that Resident #1 had never complained about Staff B going too fast or Resident #1 not feeling good that day.</p> <p>The facility provided document titled, Self Reports, revealed a report was made to the State Agency for allegation of abuse involving Resident #1 on 1/18/25.</p> <p>(continued on next page)</p>		

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