

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Southern Hills Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 444 North West View Drive Osceola, IA 50213	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on clinical record review, facility record review, video evidence, staff interview, and facility policy review, the facility failed to provide a private space free from being recorded without their consent and free from being degraded by staff members for 1 of 3 residents reviewed (Resident #73). The Facility reported a census of 86. Findings Include: The discharge Minimum Data Set (MDS) assessment for Resident #73, dated 08/12/2025, did not document her Brief Interview for Mental Status (BIMS) score. It documented the following relevant diagnosis: unspecified dementia, unspecified severity. The Progress Notes, dated from 08/08/2025 through 08/21/2025, failed to document the incident. In an interview on 08/18/2025 at 10:53 AM with the Facility Administrator, she stated she had been alerted by Staff H, Certified Nurse Aide (CNA), of an incident involving Staff G and Resident #73 on 08/11/2025. The incident related to a recording of Resident #73, sent to Staff H via a social media platform, that showed the resident wandering. It included a message stating Look how crazy this one is. Referring to Resident #73, the message appeared to have been sent by Staff G. The Administrator reported she immediately suspended the staff member pending investigation, as well as suspended Staff H while the investigation was ongoing. At this time, the Administrator provided the video on question, sent through social media to Staff H, showing Resident #73 wandering the halls, speaking to another resident, and otherwise acting normally. The social media video contains the name of Staff G as the sender, and Staff H as the recipient. In an interview on 08/18/2025 at 02:12 PM with Staff H, CNA, she confirmed that on 08/11/2025 she had been sent a video from 08/08/2025 by Staff G. The video was confirmed to be the video showed to the investigator by the Administrator, and Staff H confirmed there was a message attached to the video calling Resident #73 crazy. Staff H stated she was not friends outside of work with Staff G, and she was unsure why Staff G sent her the video and message. She stated she is very new to being a CNA, but she knew immediately that this was a violation of the Health Information Portability and Accountability Act (HIPAA). She stated she reported it to Staff I, Assistant Director of Nursing (ADON). In an interview on 08/18/2025 at 03:25 PM with Staff I, ADON, she confirmed she took report from Staff H about a resident having been filmed without her consent and against corporate policy. Staff I reported it to the Facility Administrator and the Director of Nursing (DON), at which point both Staff H and Staff G were suspended pending investigation. She was unaware why the video was taken, but noted staff are not permitted to record/photograph residents who cannot give consent. She confirmed that Resident #73 was unable to give consent due to her diagnosis of dementia. In an interview on 08/18/2025 at 03:34 PM with the DON, she stated she received the report regarding the video from Staff I as well as a now-terminated staff who was unavailable to speak with. As soon as she was made aware, both Staff G and Staff H were suspended pending further investigation, and investigation confirmed the presence of the video taken on 08/08/2025. In an interview on 08/21/2025 at 04:36 PM with Staff G, CNA, she acknowledged she had sent the message and recorded and sent video of Resident #73. She stated she did not know why she did it, and confirmed she had sent the video to Staff H. She apologized, and acknowledge what she did was wrong, but could not provide a rationale as to why she recorded the resident. She acknowledged her statement about the resident was degrading. In an interview on 08/21/2025 at 11:14 AM she stated her expectations are for staff members to never record residents. She confirmed it is corporate policy that if they will be present in pictures of videos they have to have a signed media release and it has to be requested and signed for each appearance. She stated it is never appropriate to record a resident for personal use or for staff member entertainment, nor to share those videos on social media. Review of Staff G's employment file documented she had been previously given a written warning for sleeping on the job on 04/28/2025. It also contained documentation that Staff G had successfully completed the Iowa Department of Human Services Dependent Adult Abuse Mandatory Reporter Training on 03/14/2024. Review of a facility provided document titled Videotaping, Photographing, and Other Imaging of Residents, with a last revised date of April 2017, stated the following: 1. Staff may not take or release images or recordings of any resident without explicit written consent. Written consent must be obtained from the resident or representative prior to obtaining images or recordings of the resident for any purposes other than investigation of abuse, neglect, or emergencies, and photography obtained for personal/family use at the verbal request of the resident or family. 2. Transmitting unauthorized images of any resident through email, internet, or social media is considered a violation of resident rights. Any image or recording taken that may be construed as humiliating or demeaning to a resident or residents is considered resident abuse and will be reported and investigated as such</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, staff interview, and policy review, the facility failed to ensure foot pedals were applied to residents' wheelchairs during transport for 2 of 2 residents (#11, #22) reviewed. The facility reported a census of 86 residents. Findings include: 1) On 8/18/25 at 9:32 AM, observed Staff C, Certified Nurse Aide (CNA) transporting Resident #22 in his wheelchair without his foot pedals from the dining area to the bump-out (area used for residents to watch television). The Minimum Data Set (MDS) assessment for Resident #22 dated 8/07/25 revealed a Brief Interview for Mental Status (BIMS) score of 02 out of 15 which indicated severely impaired cognition. It included diagnoses of end-stage renal disease, Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and reduced mobility. It indicated Resident #22 was independent with toileting, required setup assistance for eating, moderate assistance for oral and personal hygiene, dressing, and footwear, and maximal assistance with bathing. It also indicated he was independent with mobility except supervision with shower transfers. It further indicated he used a manual wheelchair. The Care Plan dated 12/09/24 indicated the resident used a manual wheelchair for long distances. On 8/20/25 at 10:38 AM, Staff C stated residents who are transported in wheelchairs by staff should have pedals on their chair. She stated Resident #22 should have had pedals on his wheelchair since she pushed him but didn't think about it because the resident is typically independent with mobility. 2) On 8/19/25 at 9:00 AM, observed Staff F, CNA transporting Resident #11 out of her room in her wheelchair without foot pedals. The Minimum Data Set (MDS) assessment for Resident #11 dated 8/07/25 revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated moderately impaired cognition. It included diagnoses of end-stage renal disease, non-Alzheimer's dementia, diabetes mellitus (DM), and abnormalities with gait and mobility. It indicated Resident #11 required setup assistance for eating, maximal assistance with bathing, was dependent with toileting, and required moderate assistance with all other ADL's and mobility. It further indicated she used a manual wheelchair. The Care Plan revised 8/18/25 indicated the resident used a wheelchair at times but only wanted one pedal on it. On 8/20/25 at 11:54 AM, Staff F, CNA stated staff have to make sure residents' legs are on the pedals and their arms are inside the chair when transporting residents in a wheelchair. She also stated there were no residents who could be transported without pedals. She further stated Resident #11's wheelchair had only one (1) pedal per the resident's request. On 8/20/25 at 3:22 PM, the Director of Nursing (DON) stated staff should have gotten the residents' foot pedals and offered it to the residents. If the residents refused, then it should be documented. A policy titled Safety and Supervision of Residents revised 7/2017 indicated employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on direct observation, staff interview, and facility document review, the facility failed to serve food in a manner that prevents cross contamination and promotes food hygiene. The facility reported a census of 86. Findings include: A direct observation of the lunch meal on 08/19/2025 at 12:39 PM revealed Staff M, Certified Nurse Aide (CNA), take a crescent shaped rocker style knife from the dining cart and cut the food of several residents. During the observation, after cutting the first resident's food, she cut the food of Resident #2 after the resident had begun to touch and cut her own food. The resident was observed licking her finger and touching her food before Staff M, CNA, used the rocker knife to cut her food. After cutting this resident's food, Staff M proceeded to cut the food of 7 more residents. At no point during the observation did Staff M change utensils or sanitize the rocker knife. The rocker knife was carried through the dining hall without a cover and was observed visibly soiled with food. After she was done cutting food for residents, she placed the rocker knife in a dirty dish bin and assisted residents with eating. In an interview on 08/21/2025 at 09:36 AM with Staff M, CNA, she stated she does not normally cut residents food in the manner she did on that day and acknowledged it was a mistake. She stated she knew it was a cross contamination issue but stated she was attempting to catch up on the delayed dining service. She stated she had already been talked to by facility administration and would not do this again. In an interview on 08/21/2025 at 09:43 AM with Staff B, CNA, she stated she would never use the same utensil to cut up multiple resident's foods. She stated they are trained to use the resident's silverware if they are requested to cut food, and to practice hand hygiene before and after. She stated it is a cross contamination issue at it's finest. In an interview on 08/21/2025 at 09:14 AM with Staff L, Licensed Practical Nurse, she stated they are trained to use a resident's own silverware to cut a resident's food up when requested. They are not to share utensils between residents and she would never use a rocker knife to cut a residents food for them unless it was their own assigned utensil. She stated if she accidentally cut food for a resident using cross contaminated silverware she would get the resident new food. In an interview on 08/21/2025 at 09:56 AM with the Director of Nursing (DON), she acknowledged she was made aware of the incident in the dining hall earlier in the week and confirmed it was an unacceptable practice. She stated her expectation is for staff members to use a resident's own utensils and to not share utensils between residents. She stated there would be a Performance Improvement Plan (PIP), related to the incident in the dining room, as it has been a repeat issue in the dining hall during the last three surveys. During the interview it was brought up that there had been an email chain between the Administrator, Dietician, and other supervisory staff on 08/15/2025 in which they had acknowledged dining service needed more oversight to reduce issues. Review of a facility provided document titled Assistance with Meals, with a last revised date of July 2017, stated the following: All employees who provide resident assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene and safe food handling.</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>Based on review of Certification and Survey Provider Enhanced Report (CASPER) from the Centers for Medicare & Medicaid Services (CMS), staff interview, and review of the facility QAPI (Quality Assurance Performance Improvement) plan, the facility failed to ensure an effective process to address previously identified quality deficiencies. This resulted in the facility receiving a Sanitary food serving deficiency for the third consecutive recertification survey. The facility reported a census of 86 residents. Findings Include: The CASPER report, dated 08/13/2025, documented the facility had been cited by the Iowa Department of Inspections, Appeals, and Licensing for failures to serve food in a sanitary manner, resulting in an F0812 deficiency, twice in 2024. At the conclusion of the recertification survey on 08/21/2025, the facility was found to again be in non-compliance for Sanitary Food serving practices. The QAPI policy, last revised in 2020, identified a monitoring process which included multiple sources of data. It did not identify a process to address repeat deficiencies. In an interview on 08/21/2025 at 09:56 AM with the Director of Nursing (DON) in her role as the Quality Assurance Officer, stated they will be implementing a Performance Improvement Plan (PIP), related to the repeat deficiency. She stated facility leadership had identified issues in the dining room prior to the 08/18/2025 survey, but they had not yet implemented a plan on action before the start of the survey. She acknowledged the previous attempts at correcting the sanitary serving issues had failed.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observations, staff interview, and policy review the facility failed to disinfect a mechanical lift after use between 3 of 3 residents (#3, #16, #45), failed to don appropriate Personal Protective Equipment (PPE) during the transfer for 1 of 1 resident on Enhanced Barrier Precautions (EBP), failed to maintain 1 of 1 resident's indwelling catheter bag below the resident's bladder during transfer, and failed to perform hand hygiene for 1 of 1 resident when moving from dirty to clean equipment. The facility reported a census of 86 residents. Findings include: 1) The Minimum Data Set (MDS) assessment for Resident #3 dated 6/12/25 revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of atrial fibrillation (irregular heartbeat), neurogenic bladder (improperly functioning bladder caused by nerve damage), multiple sclerosis, and seizure disorder. It indicated the resident was dependent with all aspects of Activities of Daily Living (ADLs) and mobility. The Electronic Health Record (EHR) included an order for EBP due to suprapubic Foley (urinary catheter that is surgically inserted directly through the bladder wall). The Care Plan revised 4/25/25 directed staff to position catheter bag and tubing below the level of the bladder and away from the entrance door.2) On 8/18/25 at 11:33 AM, Staff A, Certified Nurse Aide (CNA) used a mechanical lift to transfer Resident #45 from her bed to her wheelchair. Staff A exited Resident #45's room with the mechanical lift and pushed it directly into Resident #16's room. Staff A and Staff B, CNA used the mechanical lift to transfer Resident #16 from her bed into her wheelchair. Staff B transported Resident #16 to the dining area. Staff A pushed the mechanical lift into Resident #3's room to transfer him to his wheelchair. Staff A and Staff B, CNA donned gloves upon entering the resident's room. Staff A repositioned Resident #3's urinary catheter bag on his shins and connected the resident's transfer sling to the mechanical lift. She raised Resident #3 off of the bed and the partially full catheter drainage bag was observed hanging above the resident's bladder on a V shape area (shape made by crossing the sling components that support the legs) of the sling. After the resident was positioned over his wheelchair, Staff A grabbed the resident's tube-feeding (TF) equipment (pump and tube-feeding bag), unfastened them from the bedside pole, and handed them to Staff B. Neither staff donned a protective gown before manipulating the resident's urinary catheter bag and Staff A did not perform hand hygiene or change gloves between handling the urinary bag and the resident's tube feeding equipment. At 11:42 AM, Staff A pushed the mechanical lift out of Resident #3's room and placed it against the wall outside another resident's room. Staff A did not sanitize the mechanical lift before or after each resident use. On 8/20/25 at 10:09 AM, Staff C, CNA and Staff D, CNA stated PPE gowns are always required when handling Resident #3's urinary catheter and anytime a catheter is manipulated. Staff C stated sometimes staff only wears gloves when transferring Resident #3 but added the gown and gloves are used to protect both the resident and staff. Staff D also stated the catheter bag could be a source of infection to both staff and a resident if staff weren't wearing PPE. She also confirmed Resident #3 was on EBP and both acknowledged staff should wear a protective gown and gloves while transferring Resident #3. On 8/20/25 at 10:05 AM, Staff E, Assistant Director of Nursing (ADON) and Infection Preventionist (IP) stated shared equipment (i.e. mechanical lifts) should be disinfected after every use and before each use in case previous disinfection is unknown. On 8/20/25 at 10:36 AM, Staff C stated mechanical lifts should be wiped down after each use before being used for another resident. On 8/20/25 at 3:22 PM, the Director of Nursing (DON) stated staff should have sanitized the equipment between each use. She also stated the catheter bag should have been kept below the resident's bladder during transport, and staff should have removed gloves, sanitized hands, and replaced their gloves before handling the TF equipment. A policy titled Cleaning and Disinfection of Resident-Care Items and Equipment revised 10/2018 indicated reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). A policy titled Catheter Care, Urinary revised 9/2014 directed staff that the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. It also directed staff to use standard precautions when handling or manipulating the drainage system. An undated facility sign titled Enhanced Barrier Precautions indicated: PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities: Dressing/Bathing/Showering/Transferring/Changing Linens/Providing Hygiene/Changing briefs or assisting with toileting/Device care or use: central line, urinary catheter, feeding tube, tracheostomy/Wound Care: any skin opening requiring a dressing</p>		