STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165341	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oelwein Health Care Center	600 Seventh Street SE Oelwein, IA 50662

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** 50874 Based on clinical record review, the Centers for Medicare and Medicaid Services (CMS) Long term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to complete a Significant Change Status Assessment (SCSA) Minimum Data Set (MDS) Assessment timely upon hospice election for 1 of 2 residents reviewed on hospice services (Resident #2). The facility reported a census of 45 residents. Findings include: An Electronic Healthcare Record (EHR) Progress Note dated 3/3/25 at 12:18 PM revealed a referral had been made for hospice care services. The hospice care provider scheduled an onsite visit for 3/4/25. An EHR Progress Note dated 3/3/25 at 2:00 PM documented family agreeable to hospice consultation. The EHR census detail page failed to document hospice as the primary payer for Resident #2 effective 3/4/25. An EHR Progress Note on 3/10/25 at 9:03 AM documented Resident #2 had been admitted to hospice care services. The MDS 3.0 Summary page in Resident #2 EHR revealed the facility failed to complete the SCSA MDS when hospice services had been elected within the required timeframe. A review of the hospice clinical record revealed the following: * The Hospice Election Packet signed by Resident #2's family member documented the start of service date as 3/4/25. * The hospice Interdisciplinary Group Meeting dated 3/19/25 at 1:00 PM documented a current admission status for Resident #2 admitted on [DATE]. * The physician Progress Note dated 03/17/25 at 11:57 AM documented the certification of terminal illness for hospice admission. The Progress Note had been electronically signed by the physician on 3/17/25 at 12:13 PM. (continued on next page)

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	During an interview on 3/26/25 at 11:09 AM with Staff A, Licensed Practical Nurse (LPN) acknowledged Resident #2 had been on hospice care services. During an interview on 03/26/25 at 11:12 AM, the MDS Coordinator, acknowledged she is responsible for completing all required MDS assessments. The MDS Coordinator revealed Resident #2 elected hospice services on 3/12/25. The MDS Coordinator revealed SCSA MDS had been in process and would be completed on 3/26/25. The MDS Coordinator revealed she follows the RAI manual when completing required assessments. During an interview on 03/26/25 11:20 AM the Director of Nursing (DON) acknowledged Resident #2 had been admitted to hospices services on 3/4/25. The DON revealed she did not know when the SCSA MDS had to be completed and would need to check with the MDS Coordinator. During an interview on 3/26/25 at 11:24 AM with the DON and MDS Coordinator, the MDS Coordinator acknowledged hospice care services had been elected on 3/4/25. The MDS Coordinator acknowledged she failed to complete the SCSA MDS within the required timeframe. The MDS Coordinator revealed the SCSA MDS should have been completed by 3/17/25. The LTC RAI 3.0 User's manual Version 1.19.1 October 2024 documented the RAI states an SCSA is required to be performed when a terminally ill resident enrolls in a hospice program or changes hospice providers and remains a resident at the nursing home. The RAI Manual specified the SCSA MDS completion date is 14 days from the determination that a significant change in resident status occurred (determination date plus 14 calendar days). The Federal regulations at 42 CFR (Code of Federal Regulations) 483.20 (b)(2)(ii) states the facility must conduct a comprehensive assessment of a resident in accordance with the time frames specified.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42134 Based on observation, clinical record review, Long-Term Care (LTC) Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to ensure the Minimum Data Set (MDS) Assessment accurately reflected the health status of 1 of 4 residents reviewed for MDS accuracy (Resident #6). The facility identified a census of 45 residents. Findings include: Resident #6's MDS dated [DATE] documented the resident did not use a feeding tube. The MDS documented no calories or fluid intake through a feeding tube. Resident #6's MDS dated [DATE] documented the resident did use a feeding tube. The MDS documented no calories or fluid intake through a feeding tube. During an observation on 3/24/25 at 12:00 PM, Resident #6 did not have a visible feeding tube. During an observation of the Resident's room at the same time, the room lacked feeding tube equipment present. During an interview on 3/26/25 at 10:39 AM, the Director of Nursing (DON) explained Resident #6 does not have and has not had a feeding tube present. During an interview on 3/26/25 at 10:41 AM, the MDS coordinator acknowledged the MDS was coded in error. The resident should not have been coded as having a feeding tube. During an interview on 3/26/25 at 11:12 AM, the MDS coordinator explained the facility does not have a policy for completing the MDS's, they follow the RAI.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50874 Based on clinical record review and staff interview the facility failed to revise and implement interventions on the comprehensive Care Plan to include hospice services for 1 of 2 residents reviewed on hospice services (Resident #2). The facility reported a census of 45 residents. Findings include: Resident #2 Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 09 out of 15, indicating moderate cognitive impairment. The MDS documented non-traumatic brain dysfunction (damage to the brain that does not result from a blow or external force to the head, but rather from internal factors like illness, stroke, or lack of oxygen), heart failure, diabetes mellitus, and non-Alzheimer's dementia. A Hospice Election Packet signed by Resident #2's family member documented the start of service date as 3/4/25. The Care Plan initiated on 4/5/24 for Resident #2 failed to include a focus area for a terminal prognosis with election of hospice care services to include interventions directing staff on cares provided. During an interview on 3/26/2025 at 11:12 AM, the MDS Coordinator acknowledged the Care Plan should have been updated on election of hospice care services. The MDS Coordinator revealed she updates the Care Plan. During an interview on 3/26/25 at 11:20 AM, the DON revealed the MDS Coordinator is responsible for updating/revising the Care Plan.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50874 Based on observation, record review, and staff interview the facility failed to utilize proper food handling to prevent potential cross contamination of food to prevent risk of food borne illness for 3 out of 3 meals observed. The facility reported of census 45 residents. Findings include: A review of the Diet Type Report dated 3/24/25 revealed three residents with a diet texture of pureed. During observation of preparation of pureed meals on 3/25/25 at 9:00 AM, Staff B, Dietary [NAME] placed a single glove on her left hand. Staff B removed a green lid from a clear plastic container with her left gloved hand. The container held buttered bread slices. Staff B reached into the container with her left gloved hand and removed 4 slices of buttered bread and placed the bread slices into the food processor and blended them with green beans. Staff B failed to utilize proper food handling to prevent cross contamination to prevent food borne illness. When blended, Staff B placed the blended bread slices and green beans into a steam table pan. During an interview on 3/25/25 at 9:43 AM with Staff B and Staff C, Dietary Manager, Staff C acknowledge she observed Staff B remove the green lid from the clear container containing buttered bread slices with her left gloved hand, reach in and remove 4 slices of buttered bread, placing them into the food processor. Staff C revealed Staff B should have used tongs to remove the bread from the container. Staff B acknowledged she had been instructed to use tongs when handling bread. During an interview on 3/25/25 at 5:13 PM, Staff C, Dietary Manager revealed the facility failed to have a policy for food handling and follows the current Iowa Food Code. A review of the Iowa Administrative Code website (https://www.legis.iowa.gov/law/administrativeRules/rules?agency=481&chapter=34&pubDate=03-19-2025) revealed rule 481-34.6(137D) food preparation and protection. * 34.6(1) Food protection. Foods shall be processed, stored, and distributed in a manner that protects food from contamination, including cross contamination from the environment, and allergen cross contact.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 42134 Based on observation, Payroll Based Journal (PBJ) report, daily staffing numbers, schedule review, and staff interview, the facility failed to completely and accurately report the required staffing information based on payroll data to the Centers for Medicare and Medicaid Services (CMS) for Fiscal Year (FY) Quarter 1 (October 1, 2024- December 31, 2025). The facility reported a census of 45 residents. Findings include: The [NAME] PBJ report compiled and provided by CMS triggered for excessively low weekend staffing. A review of the daily staffing sheets show staffing over 2.0 hours per resident per day. A review of the nursing department schedules confirm staffing levels over 2.0 hours per resident per day. Observations across shifts from March 24, 2025 to March 27, 2025 revealed the resident's were out of bed, dressed, clean, and well kept with no odors. The resident's beds were made. During an interview on 3/26/25 at 9:40 AM, the Administrator, Director of Nursing (DON) and Human Resources explained the PBJ data is submitted by their corporate office. They explained they do not get a preliminary report to review for accuracy, it is all handled by the corporate office.