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	03/26/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on clinical record review, policy review, provider, family and staff interviews, the facility failed to notify the provider and family of a significant injury for 1 of 4 sampled residents (Resident #17). Staff identified an unexplained bruise to the resident's right eye on 3/15/26, but the facility didn't notify the medical provider or the family until 3/23/26, resulting in an 8-day delay. The facility identified a census of 51 residents.Findings include:Resident #17's Minimum Data Set (MDS) Assessment, dated 2/4/26, documented a Brief Interview for Mental Status (BIMS) score of 99, indicating severe cognitive loss. Resident #17 experienced memory problems, had moderately impaired decision-making, and was diagnosed with Alzheimer's Disease and Non-Alzheimer's Dementia. The MDS noted Resident #17 exhibited hallucinations, rejection of care, and physical and verbal behaviors toward others 1 to 3 days per week. The MDS documented no upper/lower extremity impairments in functional range of motion. The MDS listed Resident #17 as independent with sit to stand transfers and walking. The MDS included diagnoses of Alzheimer's disease and unspecified and non-Alzheimer's dementia.A General Progress Note, dated 3/15/26 at 6:00 PM, documented Staff A, Licensed Practical Nurse (LPN), arrived at Resident #17's room after a call from Staff B, Certified Nursing Assistant (CNA), and Staff C, CNA. Staff B and Staff C reported a 2 centimeter (CM) by 2 CM bruise above Resident #17's right eye.The clinical record lacked documentation from 3/15/26 to 3/22/26 indicating a provider or family member received notification of the bruise.A Physician Visit Note, dated 3/24/26 at 10:45 AM, documented Advanced Registered Nurse Practitioner (ARNP) K entered the facility to examine the bruising to Resident #17's right eye.During an interview on 3/24/26 at 2:49 PM, Resident #17's sister stated she noticed the bruise to the right eye on Saturday 3/21/26 during a visit. She stated the injury looked like someone punched Resident #17 in the eye and she took a picture. She noted the facility failed to notice the bruise until she brought it to the attention of the Director of Nursing (DON) on Monday 3/23/26.During an interview on 3/25/26 at 9:34 AM, ARNP L reported Resident #17 had a significant history of falls with head injury. ARNP L stated if staff find a resident with unexplained bruising on the face or head, they should notify her at the time of discovery, noting an eight-day wait remained inappropriate.During an interview on 3/25/26 at 11:20 AM, Staff J, LPN, reported nurses should document the area in the progress notes, complete an incident report, and notify the doctor and family.During an interview on 3/25/26 at 1:41 PM, Staff D, CNA, reported she noticed the bruising around Resident #17's right eye the previous weekend. She stated she informed Staff E, Certified Medication Aide (CMA), that day, and Staff E replied the nurses already knew about the bruise.During an interview on 3/25/26 at 2:11 PM, Staff F, Registered Nurse (RN), reported she saw the bruise above Resident #17's right eye during the previous week. She noted upon her return to work on Monday 3/23/26, the bruising had moved below Resident #17's right eye.During an interview on 3/25/26 at 2:39 PM, Staff G, CNA, reported she saw Resident #17's bruising to the right eye on 3/20/26 and 3/21/26 during her 10:00 PM to 6:00 AM shift.During an interview on 3/25/26 at 4:17 PM, Staff H, CNA, reported she saw Resident #17's bruising during the previous week and observed the bruise worsened by the end of the week.During an interview on 3/25/26 at 4:35 PM, Staff I, CNA, explained she first saw Resident #17's bruising around the right eye (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 3/15/26 at suppertime. She described it as a small bruise around the right eye.During an interview on 3/25/26 at 4:45 PM, Staff B reported she and Staff C put Resident #17 to bed on 3/15/26 between 6:00 PM and 7:00 PM. She stated Resident #17's right eye appeared black at that time and they called Staff A to report it.During an interview on 3/26/26 at 8:02 AM, Staff A recalled recalled a call to Resident #17's room to observe a bruise above the right eyebrow. Staff A described the bruise as small measuring 2 CM x 2 CM on 3/15/26. Staff A reported she did not notify the provider or family because of the late hour. When inquired about the progress note written about the bruise at 6:00 PM, Staff A replied if it was documented at 6:00 PM, then that was when it happened. Staff A explained she worked Friday, Saturday, Sunday. Staff A confirmed the bruising darkened until Resident #17 had a black eye.During an interview on 3/26/26 at 9:52 AM, Staff M, LPN, reported if she found new bruising on a resident, she would notify the physician and family as soon as possible.During an interview on 3/26/26 at 11:22 AM, the DON reported she became aware of the situation on 3/23/26 when Resident #17's sister notified her. The DON stated while she felt unsure how timely the policy required family notification, the eight-day delay exceeded acceptable limits.The facility's Notification for Change of Condition Policy, revised June 2023, directed the facility must immediately inform Resident #17, consult with the physician, and notify Resident #17's legal representative or family member when an accident occurs resulting in injury with the potential for requiring physician intervention.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and staff interview, the facility failed to ensure a complete medical record for 2 of 4 sampled residents (Resident #4 and Resident #8) by failing to maintain copies of hospital transfer documentation in the clinical records. The facility reported a census of 51 residents. Findings include:1. Resident #4's Minimum Data Set (MDS) Assessment, dated 12/3/25, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating she remained cognitively intact. The MDS indicated Resident #4 required staff dependence for transfers, did not walk, and carried diagnoses of malnutrition (a condition where the body does not get enough nutrients), pressure ulcer (a sore caused by prolonged pressure on the skin), and paraplegia (paralysis that affects the lower half of the body).Review of Resident #4's Progress Notes, dated 1/17/26 at 12:25 PM, documented an ambulance arrived to transport Resident #4 to the hospital.During an interview on 3/25/26 at 10:29 AM, Resident #4 stated she required a mechanical sling lift (a device used to help move people who have limited mobility) with two-person assistance for all transfers. She reported her last hospitalization resulted from an infection and emphasized multiple times the facility was not responsible for the illness.2. Resident #8's MDS Assessment, dated 12/17/25, documented a BIMS score of 15, indicating no cognitive impairment. Resident #8 carried diagnoses of paraplegia, diabetes (a disease that occurs when your blood glucose is too high), and anxiety (a feeling of fear, dread, and uneasiness).A Health Status Note in the Progress Notes, dated 2/5/26 at 4:22 AM, documented Resident #8 entered the local hospital for sepsis (a life-threatening medical emergency where the body has an extreme response to an infection) and a urinary tract infection (UTI) (an infection in any part of the urinary system).During an interview on 3/25/26 at 9:44 AM, Advanced Registered Nurse Practitioner (ARNP) L reported Resident #8 experienced a rapid onset of illness and stated they can become septic quickly, requiring an immediate transfer to the emergency room (ER), which staff cannot always prevent.In e-mail correspondence dated 3/25/26 at 9:39 AM, the Director of Nursing (DON), Licensed Practical Nurse (LPN), stated the nurse on shift failed to copy the transfer paperwork sent with Resident #4 and Resident #8 during their hospitalizations. She contacted the hospital's medical records department to obtain copies and confirmed nurses must send the Resident Transfer Sheet, advance directives (legal documents that specify what actions should be taken for a person's health if they are no longer able to make decisions for themselves), Medication Administration Record (MAR), Treatment Administration Record (TAR), and pertinent laboratory or x-ray results prior to transfer.During an interview on 3/26/26 at 9:38 AM, Staff R, LPN, stated staff must send the Resident Transfer Record, MAR, immunization records, and advance directives when transferring a resident to the hospital.During an interview on 3/26/26 at 12:34 PM, the DON reported she could not locate the hospital transfer paperwork for Resident #8's 2/5/26 hospitalization or Resident #4's 1/17/26 hospitalization. She noted the local hospital provided documentation they retained from Resident #4's 1/17/26 transfer, including an admission Record and an Order Summary Report.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on record review, document review, the Center for Medicare and Medicaid (CMS) Long-Term Care (LTC) Resident Assessment Instrument (RAI) Manual and staff interview, the facility failed to ensure the timely transmission of the Discharge Return Not Anticipated (DRNA) assessment for 1 of 2 sampled residents (Resident #34). The facility transmitted the assessment 118 days after the required completion date. The facility identified a census of 51 residents:Findings include:An Electronic Healthcare Record (EHR) Census Record showed Resident #34 discharged from the facility on 11/21/25.The Minimum Data Set (MDS) Summary Page documented the DRNA Assessment completion on 11/26/25 and locking on 3/24/26.An MDS Assessment History showed the iQIES (Internet Quality Improvement and Evaluation System) (the system used to transmit resident assessments) accepted the DRNA Record with an accepted date of 3/24/26.A Batch Report (a document tracking group submissions), dated 3/25/26 at 7:28 AM, documented the acceptance of Resident #34's DRNA Assessment on 3/24/26.During an interview on 3/25/26 at 8:05 AM, Staff J, Licensed Practical Nurse (LPN), reported Resident #34 used a Medicare Advantage plan (a type of health insurance plan). She stated she believed the discharge record remained marked not to submit for that reason. Staff J reported she normally waited for the Director of Nursing (DON), to sign off the MDS records, and then she transmitted the records each week. She voiced she did not think the facility maintained a policy on transmitting MDS records and noted the facility followed the Resident Assessment Instrument (RAI) Manual requirements.The CMS LTC RAI October 2025 Manual directed in Chapter 2, page 19, that the facility required the transmission of the DRNA 14 days from the completion date.

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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, document review, Center for Medicare and Medicaid (CMS) Long-Term Care (LTC) Resident Assessment Instrument (RAI) Manual, provider and staff interviews, the facility failed to ensure an accurate picture of a resident's health status by coding a diagnosis that lacked a direct relationship to the resident's current status for 1 of 2 residents reviewed (Resident #7). The facility coded schizophrenia on the Minimum Data Set (MDS) (a resident assessment tool) based on 1990 medical records, despite a lack of supporting documentation from current providers. The facility identified a census of 51 residents.Findings include:The Electronic Healthcare Record (EHR) documented Resident #7 admitted to the facility on [DATE].Resident #7's admission MDS, dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15/15, indicating intact cognition. The MDS documented active diagnoses of generalized anxiety disorder (GAD) (a condition of excessive worry), depression, and agoraphobia with panic disorder (a severe anxiety condition characterized by fear of places where escape might be difficult). The MDS documented Resident #7 received antianxiety and antidepressant medications.A Mental Health Institute Hospital Discharge Summary, with a facsimile date of 6/24/25, documented Resident #7 had been hospitalized and discharged on 11/28/1990 with a final diagnosis of schizophrenia, residual type, and schizoid personality disorder. The discharge lacked documentation indicating the resident received quetiapine (antipsychotic medication) (a medication used to treat certain mental or mood conditions) at that time.Behavioral Health, Psychiatric Progress Notes, dated 9/10/25 and 2/25/26, documented Resident #7 prescribed quetiapine for diagnoses of major depressive disorder, post-traumatic stress disorder (PTSD), and GAD.A 10/22/25 Behavioral Health Therapist Visit Note, documented by a Licensed Social Worker (LISW), listed visit diagnoses including GAD, schizoid personality disorder, and agoraphobia with panic disorder. The note documented a 30-minute consultation performed over the telephone and included an order for quetiapine with no diagnosis listed.Facility Visit Notes, documented by Resident #7's primary provider on 11/19/25, 1/14/26, and 3/4/26, included an active problem list but lacked a current diagnosis of schizophrenia or schizoid personality disorder. The notes listed an active physician order for quetiapine without an actual diagnosis on the order.The 2/11/26 quarterly MDS lacked documentation of active delirium, behaviors, hallucinations, or delusions. The MDS listed a new diagnosis of schizophrenia and documented Resident #7 received antipsychotic medication.A Medication Order Entry Audit Detail Report detailed the Director of Nursing (DON) (the person in charge of nursing services) entered an order for quetiapine in the EHR on 2/25/26 at 12:48 PM with a diagnosis of residual schizophrenia.During an interview on 3/25/26 at 11:50 AM, the Psychiatric Nurse Practitioner (PMHNP), an Advanced Registered Nurse Practitioner (ARNP) specializing in mental healthcare, stated that in June 2025, Resident #7 exhibited behaviors including not sleeping, anxiety, agitation, rudeness, and pacing. She reported starting the resident on quetiapine for off-label use (prescribing a medication for a condition other than what it is officially approved for) to treat panic-type anxiety, agoraphobia, and PTSD. The PMHNP noted she saw old documentation from 1990 where Resident #7 had a diagnosis of schizophrenia and schizoid personality disorder. She stated she had not diagnosed the resident with those conditions herself, nor had she seen other providers do so. She confirmed she had not treated Resident #7 for schizophrenia or schizoid personality disorder and did not feel those diagnoses were relevant to the resident's current condition.During an interview on 3/25/26 at 3:10 PM, Staff J, Licensed Practical Nurse (LPN), explained she coded active diagnoses treated within the last seven days on the MDS. She stated she coded schizophrenia on the 2/11/26 MDS after the facility received 1990 records and admitted she never verified with providers if the diagnosis remained current, as the DON did that.During an interview on 3/25/26 at 3:23 PM, the DON reported the psychiatric ARNP only examined Resident #7 at the facility. The DON stated she did not know the criteria for coding diagnoses on the MDS. She (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	explained she retrieved the schizophrenia diagnosis from 1990 mental health records when she entered the quetiapine order into the EHR.The DON reported she spoke with the psychiatric ARNP, who expressed uncertainty regarding the accuracy of the original diagnosis but did not clarify if it remained current. After reviewing the psychiatric ARNP's visit notes, the DON confirmed she found no documentation to support a schizophrenia diagnosis. She stated the inclusion of schizophrenia on the MDS was a coding error.During an interview on 3/25/26 at 5:03 PM, the Primary ARNP for Resident #7 reported she would defer psychiatric diagnosis and medication regulation to the psychiatric provider.During an interview on 3/26/26 at 11:58 AM, the Mental Health Licensed Social Worker reported she pulled the diagnosis of schizoid personality disorder from the facility diagnosis sheet for the Therapist Visit Note on 10/22/25. As it didn't have a resolved date, she thought it was a current diagnosis. She stated she did not provide diagnoses as part of her treatment sessions.The Centers for Medicare & Medicaid Services (CMS) Long-Term Care (LTC) Resident Assessment Instrument (RAI) Manual, Chapter 3, directed the facility to code diseases having a direct relationship to the resident's current status. The manual stated the MDS assessment should generate an accurate picture of the resident's health status based on active diagnoses in the last seven days.A 3/26/26 review of the manufacturer's Highlights of Prescribing Information for quetiapine documented the initial United States approval for the medication occurred in 1997.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, document review, family, staff, and physician interviews, and policy review the facility failed to ensure clinical monitoring and physician notification for critical lab values and significant injuries for 3 of 10 sampled residents (Resident #5, Resident #25, and Resident #17). Specifically, the facility failed to notify providers of dangerously high and low blood sugar readings and failed to perform neurological assessments for a resident with an unexplained head injury. The facility reported a census of 51 residents. Findings include: 1. Resident #5's Minimum Data Set (MDS) Assessment, dated 12/10/25, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating she remained cognitively intact. The MDS documented she received daily insulin and carried diagnoses of fracture, diabetes (a disease that occurs when your blood glucose is too high), and long-term insulin use. Review of Resident #5's Blood Sugar Summary from 1/30/26 to 3/26/26 documented blood glucose levels less than 60 milligrams per deciliter (mg/dL) or greater than 450 mg/dL. Readings below 65 mg/dL indicate hypoglycemia (low blood sugar), while readings over 450 mg/dL indicate severe hyperglycemia (high blood sugar); both conditions require prompt action and medical consultation: a. 1/30/26 at 7:56 AM: 58 mg/dLb. 1/14/26 at 8:26 PM: 461 mg/dLc. 1/20/26 at 8:34 PM: 483 mg/dLd. 2/7/26 at 8:39 AM: 55 mg/dLe. 2/14/26 at 8:13 AM: 43 mg/dLf. 3/2/26 at 7:21 PM: 457 mg/dLg. 3/21/26 at 8:41 PM: 515 mg/dL A review of Resident #5's Progress Notes on 3/26/26 revealed a lack of notification to the provider regarding the blood sugars listed. During an interview on 3/26/26 at 9:38 AM, Staff R, Licensed Practical Nurse (LPN), stated Resident #5's provider, Advanced Registered Nurse Practitioner (ARNP) K, required notification for blood sugar readings less than 70 mg/dL or greater than 450 mg/dL. Staff R further stated that nurses are expected to document the physician communication in the resident's Progress Notes. Review of Resident #5's current Care Plan on 3/26/26 documented that she remained at risk for complications related to diabetes. The established goal was for the resident to remain free of complications related to hyperglycemia and hypoglycemia. The facility implemented interventions to monitor blood glucose levels as ordered and to report findings outside of specified parameters to the provider. 2. Resident #25's MDS, dated [DATE], documented a diagnosis of type 2 diabetes mellitus with diabetic neuropathy (a condition causing high or low blood sugar), schizoaffective disorder, bipolar type (a chronic mental health condition), chronic kidney disease (a condition where kidneys cannot filter blood properly), heart failure (a condition where the heart cannot pump blood efficiently), and obesity. The Progress Notes in the Electronic Healthcare Record (EHR) lacked documentation the facility notified the physician of blood sugars above 450 mg/dL on the following dates: a. 3/5/25 at H.S. (bedtime): 480 mg/dLb. 3/6/26 at H.S.: 483 mg/dLc. 3/7/26 at H.S.: 510 mg/dLd. 3/8/26 at supper time: 539 mg/dLe. 3/15/26 at lunch: 522 mg/dLf. 3/22/26 at H.S.: 533 mg/dL (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/26 at 12:35 PM, the Director of Nursing (DON) verbalized the facility had the parameters posted in the medication room. Each provider has its own set of blood sugar parameters, if not specific parameters for each diabetic resident. She stated she expected staff to notify the physician for orders if blood sugar was below or above parameters. If the DON saw they had high blood sugars for a few days in a row, she'd send them to the physician for review. In an email dated 3/26/26 at 1:30 PM, the DON confirmed Resident #25's chart lacked documentation of physician notification. The facility policy titled Diabetes Management (hyperglycemia/hypoglycemia) directed staff to notify the physician of clinical condition, including vital signs and blood glucose levels, during hyperglycemia. 3. Resident #17's MDS Assessment, dated 2/4/26, documented a BIMS score of 99, indicating severe cognitive loss. Resident #17 exhibited memory problems. The MDS noted Resident #17 exhibited hallucinations (perceptual experiences in the absence of real external sensory stimuli), physical and verbal behaviors toward others, and rejection of care 1 to 3 days per week. The MDS included diagnoses of Alzheimer's disease and non-Alzheimer's dementia. The Care Plan Focus dated 12/23/24 indicated Resident #17 had a risk of elopement. The Interventions directed staff to redirect Resident #17 from entering other resident rooms and to common areas as needed. The Care Plan Focus dated 1/6/25 indicated Resident #17 had a risk for falls. The Intervention directed the staff to redirect Resident #17 if observed walking toward a resident in a wheelchair to prevent further falls. The Care Plan Focus dated 4/1/25 indicated Resident #17 required assistance with her activities of daily living. The Interventions instructed the following:a. Attempt to redirect Resident #17 if they walk too close to wheelchairs to prevent injury to her feet.b. Resident walked and transferred independently. A Progress Note, dated 3/15/25 at 6:00 PM, documented Staff B, Certified Nurse Aide (CNA) and Staff C, CNA, summoned Staff A, LPN, to Resident #17's room to report a 2 centimeter (CM) by 2 CM bruise to her right eyebrow. The Progress Notes from 3/15/26 to 3/22/26 lacked documentation of further assessment or neurological assessment (an evaluation of sensory and motor responses to determine if the nervous system is impaired). An Incident Report, dated 3/23/26 at 12:28 PM (8 days later), documented Resident #17 had a bruise under her right eye. The report detailed the bruise over the eye moved underneath the eye. The Incident Report under List Any Treatment Provided documented Assessment. The Incident Report identified new interventions for Physical/Occupational Therapy to evaluate and treat and to attempt the use of a soft helmet. A Secure Conversation Note, dated 3/23/26 at 12:51 PM, documented the DON notified ARNP L of the bruise under Resident #17's right eye, of unknown origin. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A General Progress Note dated 3/23/26 at 1:36 PM documented the DON placed a soft helmet on Resident #17. A Physician Visit Note dated 3/24/26 at 10:45 AM documented ARNP K examined Resident #17's bruising to her right eye while in the facility. During an interview on 3/25/26 at 9:34 AM, ARNP L reported Resident #17 has a significant fall with head injury history. She explained that with unexplained bruising to the head/face, neurological changes would be of concern. She'd expect a neurological assessment at the time the bruising was discovered, noting an 8-day wait remained inappropriate. If there were changes, she'd want the resident sent out for a potential bleed or neurological changes right away. A 3/25/26 review of Resident #17's EHR Assessments showed Skin Evaluation Non-Pressure Wound monitoring dated 3/3/26, 3/17/26 and 3/17/26 for facial bruising to the left side of the face from a fall sustained on 3/2/26. The EHR Assessment showed a Skin Evaluation for bruising to the right eye wasn't started until 3/24/26. During an interview on 3/25/26 at 11:20 AM, Staff J, LPN, reported she started a skin sheet weekly during rounds, on Tuesdays. She stated nurses should document the area in the progress notes. Staff J then picks up the skin sheet during the week when she did her wound care documentation. Staff J added the facility just implemented a soft helmet that week for Resident #17. During an interview on 3/25/26 at 1:05 PM, Staff O, CNA, reported they noticed Resident #17 had bruising around her right eye on 3/22/26. She stated it had a green undertone, looking like an older bruise. She thought she'd seen it on 3/19/26 but didn't report it because she thought the nurses already knew. During an interview on 3/25/26 at 1:41 PM, Staff D, CNA, voiced she noticed bruising around Resident #17's right eye the previous weekend. She stated Staff E, Certified Medication Aide (CMA), told her the nurses already knew about it. During an interview on 3/25/26 at 2:11 PM, Staff F, RN, reported she saw the bruising above Resident #17's right eye the previous week. When she returned to work on 3/23/26, she saw the bruising moved below the right eye. During an interview on 3/25/26 at 4:17 PM, Staff H, CNA, reported she saw the bruise to Resident #17's right eye the previous week and it got worse by the end of the week. During an interview on 3/25/26 at 4:35 PM, Staff I, CNA, voiced she first saw a small circle of bruising to the right eye on 3/15/26 at suppertime. During an interview on 3/25/26 at 4:45 PM, Staff B reported she and Staff C put Resident #17 to bed on 3/15/26 and her right eye appeared black at that time. They called Staff A to the room to report the bruise. During an interview on 3/26/26 at 8:02 AM, Staff A recalled the call to Resident #17's room to observe the bruise. She didn't notice bruising to Resident #17's right eyebrow earlier in the shift. She added didn't know of any recent falls, altercations, incidents or anything significant that happened leading up to the bruise. Staff A explained she documented the area in the Progress Notes and then (continued on next page)

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	165341	A. Building B. Wing	03/26/2026

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	printed off the Progress Note and put it in the Director of Nursing's (DONs) box to notify the DON of the bruise. The DON usually does a small investigation into the cause of what may have happened. She explained she'd documented the area but didn't perform vital signs or a neurological assessment due to Resident #17 sleeping. The nurses pass resident concerns through a verbal report and sometimes put the concerns on the Alert Charting to follow up. She couldn't recall if she put it on the Alert Charting Log but she passed it through report. Staff A voiced she knew the facility had a policy for assessing injuries but she probably didn't follow it. During an interview on 3/26/26 at 9:52 AM, Staff M, LPN, reported if she found a new bruise on the head of a resident, she'd perform a neurological exam as soon as possible and stated 8 days later wasn't timely. She would put resident concerns on the Alert Charting Log to have the nurses get vital signs and assess for pain for 72-hours. Staff M didn't recall anything coming through shift-to-shift report to monitor Resident #17's bruise on the right eye. Unknown bruising should be assessed and monitored. She personally talked to the DON if she finds any resident injuries. She noted unknown bruising should be monitored. The Alert Charting Logs provided by the facility on 3/26/26 from 3/9/26 – 3/25/26, lacked documentation on 3/15/26 to assess or monitor Resident #17's bruising to the right eye. During an interview on 3/26/26 at 11:18 AM, the DON explained she would address using the Alert Change Log and following the facility's processes with Staff A. She didn't personally look at the Alert Charting for Resident #17's bruising. The DON explained the normal process is for the nurse to measure the area when found, document an incident report, and place the resident on the Alert Charting Log for 72 hours of observation and vital signs. The DON reported she couldn't honestly say if Resident #17 needed neurological checks as she didn't know the cause of her bruising of her right eye. The DON stated she didn't believe Staff A left any notification in her box regarding the bruise.

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure that a resident with a high risk of aspiration and difficulty swallowing was fed only by licensed or certified staff for 1 of 2 residents reviewed (Resident #20). Specifically, the facility allowed Paid Nutritional Assistants (PNAs) to assist a resident who exhibited active coughing during meals. The facility reported a census of 51 residents.Findings include: Resident #20's Minimum Data Set (MDS) assessment dated [DATE] identified they had a mechanically altered diet while a resident at the facility. The Care Plan Focus revised 11/4/24 identified Resident #20 needed assistance with activities of daily living (ADLs) related to progressing Alzheimer's and the lack of awareness on how to initiate/complete cares. The Intervention related to eating revised 12/29/25 directed Resident #20 needed assistance from 1 staff member to eat.The Care Plan Focus revised 11/5/24 indicated Resident #20 had an actual risk for altered nutritional status due to dementia. The Interventions directed the following:a. 11/5/24: Provide diet as ordered: Pureed texture with nectar thick liquids in nosy cups.b. 12/29/25: Assess for signs and symptoms of aspiration (incorrectly swallowing food into the lungs instead of the stomach) or difficulty swallowing. A Video Swallow Study, dated 12/11/25, documented Resident #20 experienced coughing during meals and carried a diagnosis of dysphagia (the medical term for difficulty swallowing). The overall impression indicated Resident #20 had a risk for aspiration (when food or liquid enters the airway). Recommendations included a diet of pureed food with mildly thick liquids and strict safe swallow precautions, such as alternating solids and liquids, taking small bites and sips, and maintaining a slow rate of intake.The PNA-Resident Dining assessment dated [DATE] reflected the following:a. A Speech Therapist indicated Resident #20 had dysphagia.i. Recommendations of general diet, pureed texture, with nectar fluid consistency and nosy cups.ii. Resident #20 tolerated the current interventions without signs of aspiration.b. Resident #20 had a diagnosis of dysphagia.c. The Interdisciplinary Team determined Resident #20 could eat with the assistance of a PNA.In an email dated 3/25/26 at 5:00 PM, the Director of Nursing (DON) stated the facility didn't have residents that PNAs couldn't assist.During an interview on 3/26/26 at 9:10 AM, Staff P, PNA, verbalized she assisted Resident #20 with breakfast and lunch every other weekend.During an interview on 3/26/26 at 12:23 PM, the Speech Therapist verbalized she didn't make the decision regarding which residents a PNA could assist; she only provided clinical recommendations. She noted she hadn't seen Resident #20 since January and couldn't speak to their current swallowing status.During an interview on 3/26/26 at 12:25 PM, Staff Q, PNA, verbalized she assisted Resident #20 with meals every evening, except Wednesdays. Staff Q reported Resident #20 coughed after every drink. She stated the other staff told her to just let her cough it out, and she didn't report the coughing to the nurse.During an interview on 3/26/26 at 12:35 PM, the DON verbalized that a PNA may assist a resident if Speech Therapy approved. She stated she her expected the PNA must get a nurse if a resident started choking or coughing, so they could evaluate and assess the resident.The facility policy titled Paid Nutritional Assistant revised May 2025 directed the following:a. Residents who exhibit concerns with recurrent lung aspiration or difficulty swallowing will be fed only by nurses, nurse aides, or other licensed health professionals.b. If the Speech Therapist and facility team determined the resident didn't have evidence in the assessment of current symptoms of choking or aspiration (which would make that resident difficult to feed) the resident is appropriate to have a PNA help them eat.

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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. Based on observation, clinical record review, policy review, Center for Disease Control and Prevention (CDC) Guidelines, resident and staff interviews, the facility failed to ensure proper hand hygiene and infection control practices were followed during the cleaning of a commode for 1 of 1 sampled residents (Resident #3). Specifically, staff failed to perform hand hygiene after glove removal, failed to properly sanitize a commode pan contaminated with fecal matter, and failed to wash hands for the required duration, creating a risk for the spread of infection.The facility reported a census of 51 residents. Findings include:Resident #3's Minimum Data Set (MDS) Assessment, dated 1/13/26, showed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. The MDS didn't list a diagnosis of dementia.The Care Plan Focus dated 2/2/26 identified Resident #3 had a risk of a chronic urinary disturbance. The Interventions directed the staff to encourage use of the commode and assist Resident #3 as needed.During an initial pool interview on 3/23/26 at 4:27 PM, Resident #3 reported only one Certified Nursing Assistant (CNA) washed their hands after emptying her commode bucket. She stated only 2 to 3 CNAs wore gloves to clean the bucket and she didn't see staff wash their hands or use hand sanitizer afterward. She noted staff sometimes refilled her water pitcher immediately after handling the commode, which she didn't like.Observation on 3/25/26 at 10:03 AM showed Staff D, CNA, assisted Resident #3 with the commode. After Resident #3 finished, Staff D removed the commode pan, which contained visible bowel movement (BM). Staff D placed the dirty pan half-tipped on the toilet seat used by Resident #3's roommate. Staff D removed her gloves and opened a drawer to retrieve a plastic bag without performing hand hygiene.Staff D applied new gloves, placed the dirty pan in the plastic bag, and returned it to the commode. She then changed her gloves again without performing hand hygiene and carried the commode over 60 feet down the hallway to the South dirty utility room. In the utility room, Staff D rinsed the pan, but visible BM remained in three different places on the rim. Staff D removed her gloves and without performing hand hygiene, left the room to get a cleaning chemical. Upon returning, she placed a glove on only her right hand without washing her hands. After spraying the pan, she washed her hands for approximately five seconds and left the area.During an interview on 3/25/26 at 10:25 AM, Staff M, Licensed Practical Nurse (LPN), verified that Staff D left the utility room without washing her hands and that visible BM remained on the commode pan. Staff M guessed the final hand wash didn't last the required 15 to 20 seconds and stated Staff D should've washed her hands after removing gloves.During an interview on 3/25/26 at 3:45 PM, Staff N, CNA, reported hand hygiene should be completed when entering and leaving resident rooms. She stated that if a commode bucket didn't rinse out, she'd sanitize it with bleach wipes and perform hand hygiene before leaving the room.During an interview on 3/25/26 at 3:54 PM, the Director of Nursing (DON) reported that best practice is for staff to perform hand hygiene after taking gloves off. She believed the facility policy required a 15 to 20 second hand wash. When asked if staff should wash hands between handling commode buckets and refilling water pitchers, she voiced, yes.The Hand Hygiene Policy, revised October 2023, documented the purpose as to prevent the spread of infection. It recommended hand hygiene before and after direct resident contact and after assisting with toileting.The Center for Disease Control and Prevention (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers, dated 2/27/24, recommended washing hands after contact with body fluids, contaminated surfaces, and immediately after glove removal. The CDC directed that handwashing include rubbing hands vigorously for at least 20 seconds and noted that gloves aren't a substitute for hand hygiene.