STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165554	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osceola Senior Living	100 Cedar Lane Sibley, IA 51249

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on record review and staff interviews the facility failed to provide professional standards of care by not following physician orders to include the updated order and the correct medication end date in the electronic record for 2 out of 12 residents reviewed (Resident #3 and #31). The facility reported a census of 34 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 documented diagnoses of Alzheimer's Disease, stroke, and hypertension. The MDS showed the Brief Interview for Mental Status (BIMS) score of 5, which indicated severe cognitive impairment. The Consultant Pharmacist Report for Resident #3 showed on 2/13/25 the physician reordered the as needed (PRN) lorazepam for a duration of 12 months. The Clinical Physician Orders for Resident #3 showed the PRN lorazepam to be last updated on 1/5/25 with an end date of indefinite. The facility failed to enter the updated order in the electronic record and failed to include the correct end date. 2. The MDS assessment dated [DATE] for Resident #31 documented diagnoses of dementia, psychotic disorder and acute kidney disease. The MDS showed the BIMS score of 6, which indicated severe cognitive impairment. The Consultant Pharmacist Report for Resident #31 showed on 12/31/24 the physician reordered the as needed (PRN) lorazepam for a duration of 3 months. The Clinical Physician Orders for Resident #31 showed the PRN lorazepam to be last updated on 9/5/25 with an end date of indefinite. The facility failed to enter the updated order in the electronic record and failed to include the correct end date. The undated Physician's Order policy identified: (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Note the order. b. Put the order in the computer. c. Order from the pharmacy if needed. d Notify the resident and the family of the new order. e. Make an entry in the progress notes regarding the order and notifications. In an interview on 3/13/25 at 9:41 AM, the Director of Nursing (DON) reported physician orders should be updated in the electronic health record and should include the correct end date. The DON reported she would follow up with the pharmacy as they are responsible for entering the orders into the electronic health records.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on observation, record review, and staff interview the facility failed to ensure a resident received Oxygen (O2) per the physician's order for 1 resident reviewed (Resident #25). The facility reported a census of 34 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #25 scored 12 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident had diagnoses including atrial fibrillation, heart failure, and a fracture. The resident did not receive oxygen (O2). The Care Plan initiated 1/8/25 identified the resident with an alteration in tissue perfusion related to Congestive Heart Failure (CHF), Atrial-fibrillation, and pulmonary hypertension. Interventions included administering medications as ordered, and monitoring and consulting with the Primary Care Provider (PCP) as needed (PRN). The Progress Notes dated 2/21/25 at 3:42 p.m. documented the Occupational Therapist (OT) reported the resident had poor activity tolerance with therapy. The OT stated the resident's oxygen (O2) saturation (sat) dropped to 82% with a short walk of 25 feet. The residents sats went up to 88% with pursed lip breathing. At 6:40 p.m. the facility received a return fax from the Certified Nurse Practitioner (CNP) regarding the resident not feeling well, his O2 sats dropping during therapy, and having a dry cough. The CNP wrote to continue to monitor, and administer O2 as needed to maintain O2 sats greater or equal to 92%. The Progress Notes dated 2/22/25 at 11:06 a.m. documented the residents vital signs included an O2 sat of 88%. The Progress Notes dated 2/24/25 at 3:47 p.m. documented a fax sent to the doctor updating him on the resident's O2 needs and sats dropping with activity. At 11:16 p.m. the resident's vital signs included an O2 sat of 89% on room air, and oxygen dropped in the 80's with activity. The Progress Notes dated 2/25/25 at 1:21 p.m. documented the resident's vital signs included an O2 sat of 91%. O2 sats continued to be less than 92% on room air, and he remained on O2 at 2 liters per nasal cannula. The Progress Notes dated 2/25/25 at 2:06 p.m. documented the resident had an O2 sat of 81% on room air while sitting in his recliner. O2 placed at 2 liters per nasal cannula and sats increased to 88%. He did not appear short of breath, and lung sounds were clear. Called the clinic, and sent a fax. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Notes dated 2/26/25 at 3:18 a.m. documented the resident's O2 sat at 89%, remaining low on 2 liters of oxygen via nasal cannula. The Progress Notes dated 3/3/25 at 10:07 a.m. the resident's vital signs included an O2 sat of 90% on 2 liters per nasal cannula. The Progress Notes dated 3/9/25 at 4:57 a.m. documented the resident's vital signs included an O2 sat of 90% on 2 liters of O2. The Progress Notes dated 3/9/25 at 12:41 p.m. documented the resident's vital signs included an O2 sat of 91% on 2 liters O2 via nasal cannula. The Progress Notes dated 3/11/25 at 10:06 a.m. documented the resident's vital signs included an O2 sat of 90%. The resident's clinical record lacked documentation the facility intervened to maintained the resident's sats at 92% or greater. On 3/11/25 at 8:32 a.m. the resident's O2 (between) 1-1/2 to 2 liters per nasal cannula. At 3:06 p.m. the resident's O2 remained at 1-1/2 to 2 liters. On 3/12/25 at 3:05 p.m. the Director of Nursing stated if the order read O2 to keep sats greater or equal to 92% she would expect the O2 would be titrated to do so. An undated facility Oxygen policy included there must be a physician's order for oxygen use which included the route and liter flow or specific oxygen, and how long oxygen was to be administered, and the nurse would monitor and document on a resident's record oxygen flowing per ordered route and rate, and respiratory status.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on clinical record review and staff interview the facility failed to address dementia/Alzheimer's Disease care on the care plan for 1 out of 5 residents reviewed (Resident #3). The facility reported a census of 34 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 documented diagnoses of Alzheimer's Disease, stroke, and hypertension. The MDS showed the Brief Interview for Mental Status (BIMS) score of 5, which indicated severe cognitive impairment. The Care Plan for Resident #3 lacked information regarding the physical, mental and psychosocial needs to support the highest practical level of well being for a resident with Alzheimer's Disease or dementia. In an interview on 3/13/25 at 9:41 AM, the Director of Nursing (DON) reported she expected Alzheimer's Disease to be included in the care plan for Resident #3. The DON reported the facility lacked a policy for Alzheimer's Disease or dementia related to the care plan.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on clinical record review and staff interview the facility failed to identify side effects, non-pharmalogical interventions to try prior to medication and specific targeted behaviors related to high risk medications in 2 out of 5 sampled residents reviewed (Resident #3 and #9). The facility reported a census of 34 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 documented diagnoses of Alzheimer's Disease, stroke, and hypertension. The MDS showed the Brief Interview for Mental Status (BIMS) score of 5, which indicated severe cognitive impairment. The Clinical Physician Orders for Resident #3 showed the following orders: a. Lorazepam (antianxiety medication) with a start date of 1/5/25, b. Quetiapine (antipsychotic medication) with a start date of 7/15/24, c. Trazodone (antidepressant medication) with a start date of 7/11/24. The Care Plan for Resident #3 revealed the facility failed to include lorazepam, quetiapine and trazodone in the care plan and failed to include specific targeted behaviors the medications are being used for and non-pharmological interventions to be tried. 2. The MDS assessment dated [DATE] for Resident #9 documented diagnoses of peripheral vascular disease, Diabetes Mellitus and stroke. The MDS showed the BIMS score of 15, which indicated no cognitive impairment. The Clinical Physician Orders for Resident #9 showed the following orders: a. Lorazepam (antianxiety medication) with a start date of 2/14/25, b. Trazodone (antidepressant medication) with a start date of 10/2/24. The Care Plan for Resident #9 revealed the facility failed to include lorazepam and trazodone in the Care Plan and failed to include specific targeted behaviors the medications are being used for and non-pharmological interventions to be tried. The Care Plan for Resident #9 also showed the facility failed to remove sertraline (antidepressant medication) from the resident ' s Care Plan when the medication was discontinued. The Clinical Physician Orders for Resident #9 showed the end date for the lorazepam as indefinite. The facility failed to obtain a specific end date for the medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/13/25 at 9:41 AM, the Director of Nursing (DON) reported she expected the care plan to identify the side effects, targeted behaviors, non-pharmacological interventions and discontinued medications should be removed. The DON also reported that lorazepam should have a specific end date. The DON reported the facility lacked a policy related to unnecessary medications.

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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. 44420 Based on observation, facility policy and staff interview, the facility failed to use proper infection control practices when hanging catheter bags for 2 of 2 residents reviewed (Residents #19 and #23). The facility also failed to complete proper hand hygiene during urinary catheter care for 1 of 1 residents (Resident #23). The facility reported a total census of 34 residents. Findings include: Observation on 3/11/25 at 9:12 AM showed Resident #19's catheter bag hanging from the garage receptacle. Observation on 3/11/25 at 9:25 AM showed Resident #23's catheter bag hanging from the garage receptacle. Observation on 3/12/25 at 10:04 AM showed Staff A, Certified Nursing Assistant (CNA) applied personal protective equipment (PPE), removed Resident 23's catheter bag from the privacy bag and emptied catheter per policy. Staff A with soiled gloves placed the catheter bag within the privacy bag. Staff A then clamped the catheter bag onto the bed frame, picked up the colander of urine from the floor with the left hand and removed the right glove. Staff A used the soiled right hand to open the resident's door, obtained hand sanitizer from the dispenser in the hall, and attempted to spread the sanitizer within the right hand as she walked to the utility room. Staff A emptied the urine into the hopper then moved the protective gown to the side to gain access to a bottle of hand sanitizer which she obtained from her pant pocket. In an interview on 3/13/25 at 9:41 AM, the Director of Nursing (DON) reported catheter bags should not be hung from garbage receptacles. The DON reported staff should not exit resident rooms to empty urine into the hopper, should not exit the room without removing PPE, and should perform hand hygiene immediately after removing soiled gloves. The undated Emptying Catheter/Catheter Care policy identified the following. The policy failed to address enhanced barrier precautions and PPE instructions: 1. Catheter care and perineal care with am and pm cares, and after each bowel movements. a. Wash hands before and after handling the catheter, tube or bag, and wear gloves, following the standard precautions for infection control. b. Clean the area where the catheter is inserted by wiping away from the insertion site, to prevent germs from being moved from the anus to the urethra. c. Hold the end of the catheter tube to keep it from being pulled while cleaning. d. Wash the catheter to remove any blood or other materials from the catheter, wiping downwards from the urethra. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Check for irritation, redness, tenderness, swelling, drainage or leaking around the catheter entry site. 2. Catheter tubing and bag. a. Check frequently to be sure there are no kinks or loops in the tubing and that the resident is not lying on the tubing. b. To prevent the catheter from being pulled out, secure the catheter tubing to the thigh without tension on the tubing. c. Always keep the bag below the level of the resident's bladder. d. Use a catheter bag cover to protect the resident's dignity. 3. Emptying the Catheter Bag. a. Empty the catheter bag at the end of every shift and when it is 2/3 full. If the bag were to fill completely, urine would back up into the bladder, causing risk of infection. b. Place a barrier on the floor beneath the bag and then place a graduate on the barrier. c. Remove the drain spout from its sleeve at the bottom of the catheter bag. Use alcohol wipe to clean spout. Open the valve on the spout and let the urine flow out of the bag into the container. d. Do not let the drain tube touch anything. e. Close the valve and use alcohol pad to clean the spout. Put the drain spout into its sleeve on the bag. f. Measure the urinary output and record in resident's record. The undated Hand Hygiene policy identified: a. Wet your hands and wrists with warm water and apply soap (DO NOT USE BAR SOAP). b. Work up a generous lather by rubbing your hands together vigorously for about 20 seconds. c. Pay special attention to the area under your fingernails and around your cuticles, and to your thumbs, knuckles, and the sides of your fingers and hands. d. Avoid splashing water on yourself or the floor. Avoid touching the sink or faucets. e. Rinse your hands and wrists well. f. Pat your hands and wrists dry with a paper towel. Avoid rubbing. g. Turn off the faucet with a dry, clean paper towel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. Hand sanitizing; i. Apply alcohol-based hand rub to the palm of one hand and then rub your hands together to cover all surfaces of the hands. j. Continue rubbing your hands together until all of the product has dried.