

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165576	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/20/2025
NAME OF PROVIDER OR SUPPLIER  Ossian Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  114 Fisher Street Ossian, IA 52161	

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 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.  (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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, staff, Pharmacist, and Physician interview the facility failed to provide timely interventions and notification to the resident's Physician after a resident presented with a low blood pressure. was lethargic, drowsy, and had blood pressure of 63/36 millimeters of mercury (mmHg) (normal blood pressure is considered to be less than 120/80 millimeters of mercury (mmHg) for one of three residents reviewed for assessment and intervention (Resident #1). The facility reported a census of 40 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented a Brief Interview for Mental Status (BIMS) of 11, which indicated moderate cognitive impairment. The MDS also identified the resident was dependent (staff did all the effort) for assistance with transfers and partial to moderate assistance (staff did less than half the effort) with bed mobility. The MDS include diagnoses of hypertension, heart failure, anemia, and fracture. Review of Resident #3's Skilled Charting assessment dated [DATE] at 11:02 PM, locked on 9/17/25 at 12:06 AM, documented vital signs of temperature 97.6 degrees Fahrenheit (F) (normal temperature 97-99 F), pulse 89 beats per minute (bpm) (normal 60-100 bpm) respiration of 16 (normal respirations 16-20), blood pressure of 63/36 mmHg (normal blood pressure, top number less than 120 and bottom number less than 80) lying down, and with a recheck blood pressure of 61/50. The document reported the resident presented as very drowsy and did answer but slept through assessment and denied pain. Review of Resident #1 Medication Administration Record (MAR) for September 2025 documented the following opioid (a type of drug that acts on the body's opioid receptors to reduce the intensity of pain signals) medication orders effective on 9/17/2025: Fentanyl patch 12 micrograms (mcg) change every three (3) days and Hydromorphone 1 milligram (mg) every six (6) hours. Review of Resident #1's ED Provider Notes from the Hospital, dated 9/17/25 at 8:11 AM, documented a chief complaint of altered mental status with low blood pressure. Review of Physical Exam section revealed Resident #1's temperature 97.9, pulse 98, respirations 29, blood pressure 89/54, and oxygen 93% (normal above 90%). The ED Provider Notes further revealed the resident had a recent thoracic spine fracture that was not operable and had been having trouble with pain management. [Resident #1] was having delusions when he was on Dilaudid (Hydromorphone), medication was decreased, [Resident #1] received Fentanyl patches, and was recently started on Risperdal 1 milligram (an antipsychotic medication, it is believed to work by balancing levels of dopamine and serotonin in the brain) twice a day. Per the primary care team the Risperdal did help the delusions as well as decreasing his Dilaudid dose. However, since last night [Resident #1] has had decreased blood pressure and altered mental status. Review of the Care Plan for pain medication therapy (Hydromorphone) included the following inventions, both dated 9/20/25: Hold medication if [Resident #1] was lethargic and/or had decreased responsiveness. Per Provider, if [Resident #1's] systolic (top number) of the blood pressure is less than 90 and/or diastolic (bottom number) is less than 60, update the provider or on call provider. An interview on 10/16/25 at 9:06 AM with Resident #1's Physician revealed he would expect to be notified of blood pressures lower than 90/50 mm/Hg. An interview on 10/16/25 at 9:24 AM with Staff D, Licensed Practical Nurse (LPN) explained the Physician increased risperidal from 0.5 mg to 1 mg, and thought low blood pressure was related to the increased dose. The resident did not sleep well the night prior and he was responsive when given his scheduled dilaudid. Staff D explained a blood pressure lower than 90/50 would require a physician notification. Staff D also explained she tried different blood pressure cuffs as she thought it was an error blood pressure reading. An interview on 10/16/25 at 11:01 AM with the facility's Pharmacist informed she would have thought a nurse would call the Physician if there was a concern related to a low blood pressure. An interview on 10/16/25 at 2:56 PM with Staff E, Certified Nursing Assistant (CNA) informed she observed Resident #1 on 9/17/25 around 12:30 AM and had no concerns with him at the time. She then revealed she observed Resident #1 more than 20 times throughout the night, and he was the same. She also revealed the nurse checked on him frequently. She then informed at about 5:30 AM his eyes were glazed and he appeared different. An interview on 10/20/25 at 2:48 PM with the Assistant Director of Nursing (ADON) revealed on 9/17/25 at approximately 6:20 AM she assessed Resident #1 with Staff D and noticed he did not present as he normally did, she assessed his blood pressure and it read 84/62. She then informed she would have expected Staff D to reassess Resident #1 blood pressure when it was 60/36 with a manual blood pressure cuff to ensure accuracy and to notify the ADON, the Director of Nursing (DON), or the on-call physician of the low blood pressure. An interview on 10/20/25 at</p>		