STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165576	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ossian Care Center	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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on personnel file review, policy review and staff interview, the facility failed to complete a thorough background check before hire for 1 of 3 staff sampled (Staff A). The facility reported a census of 42 residents.Findings include:The personnel file for Staff A, Certified Nursing Assistant (CNA) documented a hire date of 3/02/26. The Personnel File 2/12/25 Single Contact License & Background Check documented further research was required, and to await Division of Criminal Investigation's (DCI's) final response for criminal history. The Personnel File contained a Record Check Evaluation Form signed by Staff A on 2/17/25 and a Criminal History Record Check Request Form from Staff A's prior employer which contained the Criminal History results as of 2/14/25. The Personnel File failed to document the DCI's Final Criminal History Response from the prior employer to ensure Staff A had been cleared to work.On 5/05/26 at 10:36 AM Staff B, Business Office/Human Resources explained the Record Check Evaluation Consent Form is attached to the facility application form and she addresses with the employee at that time. She completes and [redacted check], SING and [redacted check]. If there is a hit on a record, she faxes the records over to the Department of Human Services (DHS) and sends them an email to ensure they receive the paperwork. They email her back the results/charges that were on the background form. During an interview on 5/05/26 at 11:35 AM, the Administrator reported the facility had not conducted a complete background check for Staff A. The facility did not have any final Record Check documentation from the prior facility showing the Staff member may work in a health care facility. The Abuse Policy dated 2/2026 directed the facility would screen potential employees for a history of abuse in accordance with state and federal laws.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and staff interview the facility failed to provide adequate supervision in the Chronic Confusion and Dementing Illness (CCDI) unit (a nursing facility unit designed to provide tailored care and a safe, home-like environment for individuals with advanced Alzheimer's disease or related dementias) to prevent a resident-to-resident altercation which resulted in two separate physical altercations and failed to provide adequate supervision to a resident that wandered into another residents room which placed a resident at risk of an altercation for 3 of 4 residents reviewed (Resident #2, #3, and #4). The facility identified a census of 42 residents.Findings include:1.An Electronic Healthcare Record (EHR) showed Resident #2 admitted to the facility on [DATE] and transferred into the CCDI unit on 1/13/26.Resident #2's Minimum Data Set (MDS) assessment dated [DATE] showed a short/long term memory impairment. Resident #2 remembered the location of her room only and had moderately impaired daily decision making. She exhibited inattention behavior continuously and disorganized thinking continuously. The MDS documented Resident #2 as independent with walking. The MDS listed diagnoses of Alzheimer's Disease with late onset and anxiety. Resident #2's Elopement Risk Assessment Checklist dated1/29/26 documented Resident #2 as up independent with walking, had a previous history of wandering, had a diagnosis of Alzheimer's Dementia, mental illness, disorientation/confusion, and resided in a locked dementia unit. Resident #2's Elopement Care Plan dated 2/7/25 documented Resident #2 wandered aimlessly looking for something to do. On 5/04/26 at 1:31 PM, Staff E, CNA voiced Resident #2 walks up right into other resident faces and usually they can redirect her. On 5/05/26 at 3:24 PM, Staff D, Licensed Practical Nurse (LPN) reported she has seen behaviors between Resident #2 and Resident #3. Resident #2 liked to pace/wander and get into other resident faces. Resident #3 didn't like other residents in his space. Staff had to constantly redirect Resident #2 and she could get pretty aggressive and hit/strike out at staff when trying to divert her from situations. Resident #2 couldn't comprehend why Resident #3 didn't want her in his personal space. They really had to keep a sharp eye on her. There was an incident where Resident #2 was coming out of her room with a family member and Resident #3 was coming out of room in his wheelchair. They had to get between the two residents or they probably would have had a resident get hit at that time. 2. An EHR Census Record documented Resident #3 admitted to the CCDI unit on 11/16/23.Resident #3's 2/12/26 MDS Assessment documented a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating severe cognitive loss. Resident #3 exhibited inattention which fluctuated in severity. Resident #3 also exhibited physical behaviors towards others 1-3 days per week. The MDS listed a diagnosis of Alzheimer's Disease, Non-Alzheimer's Disease Dementia, and adjustment disorder with mixed anxiety and depressed mood. Resident #3's Care Plan included a focus that Resident #3 had the potential to be physically aggressive, grabbing or trying to hit related to dementia and poor impulse control. The Care Plan intervention dated 4/10/24 directed if he became agitated, intervene before agitation escalates; guide away from source of distress; engage in calm conversation and ask the resident to go to his room. On 5/04/26 at 1:04 PM, Staff F, CNA reported she had worked at the facility since December 2025. Resident #3 didn't like people standing by him or talking to him. He has been that way ever since she had worked at the facility. She was told to keep residents out of his room. Some of the other residents that wander will pat others on the back or try to talk with them and he doesn't understand that. Resident #3 had yelled at other residents to get the hell away and get the f**k away from him. She had seen Resident #3 get mad at Resident #2 and point a finger at Resident #2 while yelling at her. On 5/04/26 at 2:56 PM Staff G, Registered Nurse (RN) reported Resident #2 liked to get up and get in Resident #3's face. Resident #2 seemed drawn to Resident #3. Resident #3 didn't want anyone touching him or his things. He had been that way for a long time. On 5/05/26 at 3:24 PM, Staff (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D reported she usually tried to get Resident #3 right back to his room when he got finished with his meal so that others were not getting into his personal space. 3. A Facility Self-Report Incident submitted on 3/17/26 at 9:22 AM for incident date 3/16/26 documented Resident #3 was agitated, yelling at Resident #2 to leave. The Incident Summary detailed Resident #2 had been walking around the (CCDI) unit and got too close to Resident #3 while he was eating a snack. When unit staff walked out of other resident rooms, Resident #3 had back-handed Resident #2. The Facility Self Report under Corrective Action Description documented staff were educated right away by the Director of Nursing (DON) when residents were up and moving in the unit, they needed to make sure there was always at least one person in the common area of the unit to keep an eye on the residents. A Facility Education for Dementia Care presented by the Director of Nursing (DON) documented the facility recently had a resident to resident contact within the unit and it was noted that there was an increased need for more visual monitoring. The Education directed if additional help was needed to call the (nursing home) floor staff and have someone go back to the unit while the CNAs/CMAs (Certified Medication Aide)/Nurse were in rooms with other residents. Observation on 5/05/26 at 1:15 PM revealed Staff M, CMA walked by Resident #2. Resident #2 reached out and grabbed Staff M's right arm as she walked by to go to Resident #3's room to check on him. On 5/05/26 at 2:33 PM, Staff H, CNA reported that day Resident #3 had been agitated before supper as other residents kept going in his room. Resident #3 came out for supper and was seated in his wheelchair at the far dining room table by the tub room. Supper usually ended around 6-6:15 PM. After supper, Resident #3 continued to sit in his wheelchair at the far dining room table watching television. She was in another resident's room assisting the resident into bed and Staff I, CMA was in another resident's room. As she was coming out of another resident's room, she saw Resident #3 strike Resident #2 in the right upper lip with the back of his left hand twice. She had a perfect frontal view of it. Staff H voiced she thought the incident could have been prevented as she should have taken Resident#3 back to his room after supper. Staff H reported she had not received any further guidance since the last incident other than to keep them two residents separate. On 5/05/26 at 2:52 PM, the DON reported the CCDI Unit Coordinator was going around ensuring all staff had read the updated resident's Kardex as she had asked staff earlier if they knew where to find the updated information (regarding Resident #2 and #3) and staff didn't know. The DON voiced she would ensure that Staff H received the updated information on what to do in the (dementia) unit. On 5/05/26 at 2:57 PM, Staff I reported staffing that night was just her and Staff H in the unit. Resident #3 liked his own space and they tried to keep other residents away from him. Resident #3 would strike out and hit staff during care. If it got too loud, he would yell at the ladies to shut up. Resident #3 would usually yell before he did anything. Staff H informed her Resident #3 had smacked Resident #2 in the upper lip when she came out of another resident's room. Resident #2 wandered. Prior to the incident, Resident #2 would walk up into Resident #3's personal space and they would have to redirect her back from him. They were instructed to ensure one staff member stayed out in the main area to supervise all residents but she couldn't remember when that direction was given, but they didn't want Resident #2 getting smacked or any resident getting smacked. She thought maybe the incident could have been prevented if they would have taken Resident #3 back to his room after supper. On 5/05/26 at 3:24 PM, Staff D reported she didn't not know if there had been any new interventions given regarding the two residents after the altercations. She just tried to keep the residents separated. They did have a Kardex and a report sheet they could review that may have that information. During an interview on 5/05/26 at 5:08 PM, Staff J, LPN reported she was called on the walkie talkie to come to the dementia unit the evening of the incident between Resident #2 and #3. Staff I informed her Resident #3 had hit Resident #2. When she entered the unit, Resident #2 was seated in a recliner by the nurse's desk and Resident #3 was in his room. Staff J verbalized there seemed to be an increase in resident to resident altercations in the unit. Resident #3 would sit in his wheelchair and intentionally try to trip other residents as they walked by. She had directed staff to take Resident #3 directly back to his room as soon as he was done eating his meals. Resident #3 did (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not like others in his personal space and Resident #2 didn't understand that, she would get right up into others personal space. When queried if the resident-to-resident altercation could have been prevented, Staff J responded, yes. The staff should have known Resident #3 needed to go back to his room right after meals. Resident #3 should not be left alone in the dining/common area. Some of the staff don't seem to understand that resident contact can happen very quick. It is common for Resident #2 to get up and wander. She gets more agitated and wanders more as the day goes along. They had a nursing meeting after the incident and one staff member should be in the dining/commons area supervising residents at all times. Observation on 5/06/26 at 8:19 AM revealed three staff in the CCDI Unit, the CCDI Unit Manager, Assistant Director of Nursing (ADON), and Staff M. Resident #2 got up from table [number redacted], pushed in the chair, and walked over to the dish cart and started to tidy items. Resident #3 sat at table [number redacted] in the dining room and watched television. At 8:26 AM, Resident #2 pushed the dirty dish cart out the front door of the CCDI Unit supervised by Staff M. Observation on 5/06/26 at 8:35 AM revealed the ADON and the CCDI Unit Manager assisted Resident #3 from the dining room table back to his room and shut the door, leaving six residents unsupervised in the common area. At 8:36 AM, Staff M returned to the unit with Resident #2 and then she stayed in the dining/common room area.Interview on 5/06/26 at 8:38 AM Staff M verified there were no staff in the common area when she entered back into the unit and there should be a staff member present in the main area supervising the residents at all times.On 5/06/26 1:58 PM, the CCDI Unit Coordinator reported she returned from vacation on 3/18/26 and was notified of the incident. On 3/18/26 the DON updated Resident #3's Care Plan to modify the environment, reduce noise, dim lights, take him to his room or provide 1 to 1 as needed, continue to encourage him not to lash out at other residents or staff. Resident #2's Care Plan was updated 3/18/26 by the ADON to ensure one staff member was monitoring the lobby (common area) during the late afternoon and into the evening as Resident #2 may become more persistent in looking for something to be doing. Resident #3 didn't like people in his personal space the entire time that she had worked at the facility. Resident #2 was a really friendly person. She liked to touch and tinker with things and didn't seem to recognize other resident boundaries which placed her at a higher risk. On 5/06/26 at 3:00 PM, the DON reported Resident #3 was eating pudding in the evening and Resident #2 went up to Resident #3 and attempted to assist him with his snack. When Resident #3 got upset he will swat out at others. Staff J informed her that night at 7:45 PM Resident #3 had backhanded Resident #2 in the check/neck area. At that time, they had a medication aide and a CNA on duty. It was pretty much known that Resident #3 did not like residents around him. There should have been staff supervising the residents at that time. During an interview on 5/06/26 at 3:23 PM the Administrator reported the facility didn't have a policy regarding supervision. The facility followed [State Regulation] for supervision regarding the unit. She became aware of the incident on 3/16/26 when she was in a board meeting that evening. Around 7:30 PM, Staff J came in to report the incident to the DON. The DON updated her after the board meeting. There was one CMA and one CNA staffed that evening in the unit. That was the normal staffing for the unit. Resident #3 had hit Resident #2. When queried if Resident #3 did not like residents around in his space, the Administrator responded, yes. It was in Resident #3's care plan. It was well known that Resident #2 wandered into others personal space even before Resident #2 was placed in the unit. The Administrator voiced she felt it should have been preventable. The staff should have been watching the residents. Resident #2 could be quick, helpful, and was always trying to clean or wipe something down. That did put her at more risk. 4. A Facility Investigation submitted on 4/13/26 for incident date 4/13/26 detailed on 4/13/26 at 11:51 AM, it was reported that Resident #3 back-handed Resident #2 in the common area of the CCDI unit where he was sitting as had just finished his noon meal. Resident #2 was walking around the unit and got very close to Resident #3. At the time of the incident Resident #3 was taken back to his room right away and Resident #2 was in the common area of the unit with staff supervision. The 4/13/26 Facility Self Report under Corrective Action Description documented care plans had been updated to have a CNA/CMA from the nursing home go to the unit during the noon (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meal to allow for extra staff in the unit while staff were cleaning up after the meal. A Written Account of the Incident by Staff L, CNA dated 4/13/26 at 11:51 AM documented Resident #3 was sitting at his spot at the dinner table. Resident #2 had already finished eating. Staff L cleaned up other resident's completed dinner trays. Her back was to Resident #3. In that time, Resident #2 invaded Resident #3's space. Staff L spun around and started to try to create space between the two residents. Before she could get there Resident #3 backhanded Resident #2 across the throat, not very hard, but contact happened. Resident #3 claimed that Resident #2 had hit him first. On 5/04/26 at 12:16 PM, Staff K, RN reported on that day, Resident #2 was seated at table [number redacted] and Resident #3 was seated at the last table in the dining area. Resident #2 finished eating and got up and walked down to Resident #3's table and was talking to him which irritated him. Staff K explained she was picking up dishes and dumping the dishes from table [number redacted] Staff L was wiping up the second table. Staff K further explained she was at table [number redacted] looking down picking up dishes and Staff L was looking down cleaning table [number redacted] and neither saw Resident #2 walk down by Resident #3. When she looked up, Resident #2 was standing to Resident #3's left side and it was too late. Resident #3 had swung out with the back of his left hand and hit Resident #2 in the right cheek/neck area. She went over to them as Resident #3 didn't like people near him. Resident #3 stated, go away! By that time, they separated the two residents. They had been instructed to watch Resident #2 when she was wandering to ensure she didn't get too close to Resident #3 or wander into his room. There was no special direction given as to who was to watch Resident #2, both of them should have been watching Resident #2 and #3. Resident #3 had yelled at Resident #2 to go away before there was ever physical contact. The second incident could have been prevented as they should have been watching Resident #2 as she was usually the first resident done with her meal and then gets up and starts walking around. On 5/06/26 at 9:54 AM, Staff L, stated Resident #2 was a wandering personality and liked to see what everyone was up to. The day of the incident she was at one of the dining room tables cleaning up other resident's dishes. Her back was to Resident #3 who was seated at the back dining room table. She didn't recall seeing Resident #2 walk by. By the time she spun around, it was too late. There was a table between her and the two residents that she had to try to get around to create space between the two residents. Before she could get there, Resident #3 backhanded Resident #2 in the throat. She thought that Resident #2 had touched Resident #3's shirt or something, but Resident #2 was very much in Resident #3's face. Resident #2 didn't seem to have much reaction, but Resident #3 knew that he had hit Resident #2. Staff L couldn't recall if there had been any altercations prior between the two residents, but they tried to maintain two people in the common room. It was hard to say if the incident could have been prevented as, unfortunately, there were other tasks that had to be done. On 5/06/26 at 1:11 PM, Staff G, RN reported they tried to send a staff person back to the unit during meals on the weekends if they had extra staff available, but it was hard. Sometimes they could and sometimes they couldn't and the two staff back in the unit had to do the best they could to supervise the residents. On 5/06/26 at 12:27 PM, Staff I reported they do the best they can. They don't always call nursing home staff back during the meals. They can if it is needed, but it is hit and miss if they can send someone back to the unit. On 5/06/26 at 12:34 PM, Staff M reported they did the best they can. One staff member tried to stay in the unit while the other staff member provided care to the residents. They can call up to the nursing home for staff to come back to the unit but they were not always able to get staff to come back to the unit to assist. They just had to do the best they can to supervise the residents. On 5/06/26 at 1:58 PM, the CCDI Unit Coordinator reported she was off on 4/13/26, but she did come in that night and found out about the incident. The DON directed to have an extra person during the noon meal to assist with increased monitoring of the residents. New interventions were placed in the care plans for Resident #2 and #3. The CCDI Unit Coordinator voiced there were two staff members in the dining room at the time of the incident. When queried how the resident made contact with each other, she stated that was a good question how they made contact with each other. She would hope the incident could have been (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevented, but Resident #2 was very quick. She expected the unit to be supervised. On 5/06/26 at 3:00 PM, the DON reported she was notified of the 4/13/26 incident by Staff K. There were two staff in the dining room at the time of the incident. Staff L was on the opposite side of a different table with her back to the residents and she couldn't get around the table quick enough to get to the residents. Before Staff L could get to the residents, Resident #3 backhanded Resident #2 in the right cheek/neck area. When queried if could have been preventable, the DON stated, yes. Staff L should have been positioned where she could have observed Resident #3 as she cleaned the tables. That same day they directed for there to be another staff person back there during the noon meal. They have been able to sustain that 99.9% of the time. She had not done any follow up with staff to find out if that was working.On 5/06/26 at 3:23 PM, the Administrator reported on 4/13/26 Resident #3 backhanded Resident #2 in the neck because Resident #2 got into his personal bubble. The residents were immediately separated. The 4/13/26 incident should have been preventable. She expected the residents to be supervised in the unit. During an interview on 5/07/26 at 12:02 PM, the DON reported she did not do additional staff education after the 4/13/26 incident between Resident #2 and #3. She just tried to catch staff and update them as they worked as to what was needed in the unit. 5. Resident #4's MDS dated [DATE] showed a BIMS score of 1 out of 15 indicating a severe cognitive loss. Resident #4 exhibited inattention and disorganized thinking which was continuously present. The MDS documented Resident #4 wandered daily, was independent with walking, and had diagnoses of Non-Alzheimer's Dementia and anxiety. The Care Plan dated 2/10/26 documented Resident #4 as an elopement risk/wander related to wandering aimlessly. Observation on 5/05/26 at 1:47 PM Staff M assisted a resident with an activity at table [number redacted] in the dining room with her back to Resident #2, who was seated in a recliner behind her. Staff M's back was to Resident #3's room door. At this time, Resident #4 walked into Resident #3's room and tried to open his window. Resident #3 was positioned on his right side in bed and looked directly at Resident #4 as she walked by him and tried to open the window. Resident #3 reached out and gripped his side rail on the bed in the direction of Resident #4. Resident #4 was approximately 6-10 inches from Resident #3's reach. At this time, Staff M was alerted for safety that Resident #4 had entered into Resident #3's room. At 1:52 PM, Resident #4 tried to enter into Resident #3's room again and Staff M diverted Resident #4 back to her room.