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	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ossian Care Center	114 Fisher Street Ossian, IA 52161

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on record review, staff interviews, and policy review the facility failed to ensure 1 of 16 residents Advance Directive forms was signed by the resident and their Doctor in a reasonable amount of time upon admission to the facility (Resident #9). The facility reported a census of 37 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #9 documented an admitted into the facility of 10/17/24. The MDS also documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. Record review on 11/18/24 at 2:40 PM revealed Resident #9 Advance Directives form documented Resident #9 requested an order for Do Not Resuscitate (DNR) on 10/17/24, however, the form lacked documentation of her Physicians signature giving an order for her wishes Record review of Resident #9 Medication Review Report dated 10/18/24 gave an order for DNR Code signed by her Doctor, but lacked Resident #9 request. Follow up record review of Resident #9 Advance Directive form on 11/19/24 revealed her physicians signature was obtained for her DNR order on 11/19/24. During an interview on 11/21/24 at 11:03 AM with the facilities Administrator and Director of Nursing revealed they would expect every resident Advance Directives form be signed as soon as possible upon admission to the facility or within a reasonable amount of time. Review of the facilities undated policy, Advance Directive Policy and Procedure on 11/21/24 lacked a procedure to obtain physicians signature on Advance Directive forms.

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on record review, staff interview, and policy review the facility failed to complete comprehensive Minimum Data Set (MDS) assessments resulting in failure to implement a comprehensive Care Plan for 2 of 4 residents reviewed (Resident #3 and #36). The facility reported a census of 37 residents. Findings include: 1. The comprehensive Minimum Data Set (MDS) dated [DATE] for Resident #3 documented a Brief Interview for Mental Status (BIMS) of 14 indicating no cognitive impairment. The MDS also documented diagnoses of Major Depressive Disorder, Adjustment Disorder, and Post Traumatic Stress Disorder (PTSD). During an interview on 11/21/24 at 10:26 AM with the facilities Social Worker revealed she would expect Resident #3 diagnosis of PTSD be on her Care Plan and include goals and interventions relevant to her PTSD. She revealed she did not have a process to ensure all diagnoses are routinely reviewed and implemented into the Care Plan but plans to review quarterly going forward. 2. The comprehensive Minimum Data Set (MDS) dated [DATE] for Resident #36 documented a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. The MDS also documented diagnoses of dementia and anxiety and was taking antipsychotic medications. The Care Area Assessment (CAA) of the MDS lacked staff review and documentation of his antipsychotic medications and what would be implemented into the Care Plan. Record review of Resident #36 current Care Plan on 11/19/24 Care Plan lacked instruction to staff he was on antipsychotic medications and side effects to monitor for. During an interview on 11/21/24 at 8:13 AM with the facilities MDS Coordinator revealed she would expect antipsychotic medications be on the Care Plan. During an interview on 11/21/24 at 11:03 AM with the facilities Administrator and Director of Nursing revealed they would expect resident Care Plans to address resident diagnoses of mental health and usage of psychotropic medications, side effects to monitor for, and resident specific interventions. The facility policy, MDS 3.0 Completion with a copyright date of 2023, instructed the following: a. Based on the CAA review, key findings regarding a resident's status are documented, including the nature of the condition, complications and risk factors that affect the care planning decision, factors that must be considered in developing care plan interventions, and the need for referrals or evaluation by appropriate health professionals.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on record review and staff interviews the facility failed to ensure 1 of 1 residents Preadmission Screening and Resident Review (PASRR) reflected all current diagnoses related to mental health (Resident #3). The facility reported a census of 37 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #3 documented a Brief Interview for Mental Status (BIMS) of 14 indicating no cognitive impairment. The MDS also documented diagnoses of Major Depressive Disorder, Adjustment Disorder, Post Traumatic Stress Disorder (PTSD). The MDS dated [DATE] for Resident #3 documented diagnoses of Major Depressive Disorder, Adjustment Disorder, Post Traumatic Stress Disorder (PTSD). Record review on 11/20/24 of Resident #9 current PASRR completed on 11/21/2023 lacked diagnoses of Adjustment Disorder, PTSD. During an interview on 11/21/24 at 10:26 AM with the facilities Social Worker revealed she would expect Resident #3 diagnoses of PTSD be listed on her PASRR within a reasonable amount of time once diagnosed . She revealed she did not have a process to ensure all diagnoses are routinely reviewed but plans to review quarterly going forward. During an interview on 11/21/24 at 11:03 AM with the facilities Administrator and Director of Nursing revealed they would expect every resident PASRR to reflect current mental health diagnoses.

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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** 41537 Based on record review, staff interview, and policy review the facility failed to ensure 1 of 1 residents reviewed for falls with major injury fall interventions were in place at the time of a fall when a clip alarm to alert staff a resident was moving failed to be attached to a residents clothing (Resident #36). The facility reported a census of 37 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #36 documented a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. The MDS also documented diagnoses of dementia and anxiety. The MDS revealed he is dependant on staff for walking and needs substantial to moderate assist with transfers. Record review of the facilities Root Cause Analysis for Resident #36 fall dated 9/28/24 documented his fall occurred in the facilities dementia unit lobby at 5:30 AM. Prior to the fall he was sleeping in a recliner with the foot rest up. Resident #36 used two (2) alarms, a clip alarm to his clothing and a motion sensor and they were not in use during the fall. Record review of Resident #36 Fall Root Cause Analysis Worksheet for his fall on 9/28/24 documented a list of contributing factors to be: a. Alarm not utilized b. Recent decrease/discontinue of medications c. Staff knowledge regarding his Care Plan and Alarm usage Record review of State for Resident #36 Fall Resulting in Fracture signed by the Director of Nursing (DON) on 9/30/24 revealed the following: On 9/28/24 Staff B, Certified Nurse Aide (CNA) was working in the dementia unit of the facility and during the time of Resident #36 fall reported she had been doing a lot of one on one with Resident #36 throughout the night as well as sitting next to him in the lobby. She then informed Resident #36 was resting in the recliner and both CNA's on the unit went to provide care for another resident on rounds during the time of the fall. Staff B informed she was unsure if Resident #36 was to have an alarm on while in the lobby and did not know where the Care Plan was to check it. She informed she would keep other residents doors slightly open so she could periodically monitor Resident #36 when assisting the other resident in the room. Record review of a Major Injury Determination Form for Resident #36 fall on 9/28/24 revealed his fall was determined to be a major injury by his provider on 10/2/24. Record review of Resident #36 current Care Plan on 11/19/24 instructed on 5/28/24 and intervention to have a clip alarm at all times was implemented and revised on 10/1/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/24 at 8:13 AM with the facilities MDS Coordinator revealed she revised Resident #36 Care Plan after his fall on 9/28/24 to clearly state his clip alarm is to be in place at all times. During an interview on 11/21/24 at 11:03 AM with the facilities Administrator and Director of Nursing revealed they would expect staff to follow all interventions on residents Care Plans. Record review of the facilities undated Fall policy instructed the following: Determine potential causes for the fall and add teaching and/or interventions to the plan of care to prevent another fall from occurring.

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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** 41537 Based on record review, staff interviews, and policy review the facility failed to ensure antipsychotic medication (a class of drugs used to treat severe mental health disorders and psychotic symptoms) had appropriate diagnoses for use and create resident specific interventions and medication side effects for 1 of 1 residents reviewed (Resident #36). The facility also failed to obtain informed consent for use of psychotropic medications for 1 of 1 residents reviewed (Resident #36). The facility reported a census of 37 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #36 documented a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. The MDS also documented diagnoses of dementia and anxiety, and was taking antipsychotic and antidepressant medications. Record review of Resident #36 orders in his Electronic Health Record (EHR) on 11/21/24 revealed his first order for antipsychotic medications started on 10/4/24 and had frequently changed. Record review of Resident #36 current orders in his EHR on 11/21/24 revealed the following antipsychotic medications were ordered on 11/19/2024 and currently in use: 1. Quetiapine (Seroquel) 12.5 mg bedtime for behaviors 2. Quetiapine (Seroquel) 12.5 mg daily as needed for agitation until 11/29/2024 Record review of Resident #36 Progress Note dated 11/19/2024 at 8:34 AM documented his as needed Quetiapine 12.5 mg daily as needed until 11/29/2024 was for behaviors. Record review of Resident #36 current Care Plan on 11/19/24 lacked resident specific intervention for use of as needed Quetiapine. The Care Plan also lacked instruction to staff he was on antipsychotic medications and side effects to monitor for. During an interview on 11/21/24 at 8:13 AM with the facilities MDS Coordinator revealed the facility does not have a process to obtain consent or refusal for psychotropic medications. She informed the facility will educate families but unsure what each nurse will say, and there is not a formal document with side effects and risks for usage of psychotropic medications. During an interview on 11/21/24 at 10:26 AM with the facilities Social Worker revealed she would expect Resident #36 Care Plan to have resident specific interventions for as needed antipsychotic medications During an interview on 11/21/24 at 11:03 AM with the facilities Administrator and Director of Nursing revealed they would expect resident Care Plans to address usage of psychotropic medications, side effects to monitor for, and resident specific interventions.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on observation, document review, manufacturer information, and staff interview the facility failed to have a proper system in place to ensure proper sanitation of all dishware. The facility identified a census of 37 residents. Findings include: Upon entrance to the facility on [DATE] at 10:00 AM the Administrator reported the facility had a COVID 19 outbreak with 9 residents positive for COVID 19. Observation on 11/18/24 at 10:26 AM revealed the dishwasher running with a wash temperature of 150 degrees and a rinse temperature of 151 degrees. Further observation revealed a Lo Temp Sanitizer chemical system in place running to the dishwasher. Staff K, Dietary reported they had changed the system over to a chemical sanitation system. Staff K tested the dishwasher for proper sanitation by utilizing a Hydrion test strip. After running the dishwasher through two different wash/rinse cycles, Staff K dipped the test strip into the hot water. She laid the test strip next to the test chart and stated the dishwasher was sanitizing. The test strip remained a light gray color when compared to the color chart registered at 10 parts per million (PPM). Staff K repeated the above testing again with no change noted in the test strip. Both test strips failed to change to a dark purple color to indicate a disinfection level of 50 -100 PPM. Inspection of the dish washer revealed a container of low-temperature sanitizer sitting on the floor and a chemical dispense system on the wall to the right of the dishwasher. Manufacturer Directions for Hot water Sanitizing and Chemical Sanitizing noted posted on the front panel of the dishwasher directed the following: 1. Hot Water Sanitizing a. Wash Temperature 150 degrees Fahrenheit minimum b. Rinse Temperature 180 degrees Fahrenheit minimum 2. Chemical Sanitizing a. Wash Temperature 120 degrees Fahrenheit minimum b. Rinse Temperature 120 degrees Fahrenheit minimum. A 11/18/24 11:39 untitled document provided by the facility contained a service note for the dishwasher noting the dishwasher tested too low for chemical disinfection. The product line was disconnected from the injection port and the port was plugged. The line was hooked up to a different port and the dishwasher tested fine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/20/24 at 11:45 PM the Certified Dietary Manager (CDM) reported they had the dishwasher inspected on 11/18/24 and found a crack in one of the dispensing lines and another dispensing line for the sanitizer had blown off the back of the dishwasher. Their vendor had fixed the issue on 11/18/24 after the surveyor identified the dishwasher had not been sanitizing the dishes. Interview on 11/20/24 at 1:30 PM the CDM voiced the sanitation strips on the dishwasher are run three days a week by the 8:00 AM dishwasher. If they do not do the test strip, then she does it. She didn't keep the strips prior to 11/09/24 because all the testing strips turn back to a light tan color. A review of the November 2024 Dish Machine Temperature Chart revealed no documented test strips prior to 11/09/24. The Chart revealed the only testing completed on 11/09/24 and 11/13/24 were a tan color so documentation could not support if the dish machine was properly sanitizing. The November 2024 Dish Machine Temperature Chart documented a wash temperature ranging from 151 to 155 degrees and a rinse temperature ranging from 109 to 122 degrees. On 12:54 PM the CDM reported she could not find the Dish Machine Temperature Chart Documentation for October 2024. The CDM could not verify the last time the dishwasher had actually been sanitizing based on the documentation. The CDM reported Staff L, Dietary staff, signed she completed the sanitation strip test on 11/09/24. On 11/20/24 at 1:25 PM Staff L, Dietary, verbalized she runs the dish washer in the kitchen, but she only works in the kitchen about every three weeks. She doesn't recall running the test strip check on the dishwasher on 11/09/24. Normally they ask the CDM for a test strip. They place the test strip on a fork and put it on a rack. They run a load of dishes through the machine. The test strip will turn yellow. She hasn't done a test strip on the dishwasher for around a year. If the dish machine is not correctly sanitizing, she would notify the CDM. Interview on 11/20/24 at 1:32 PM Staff G, Certified Nursing Assistant (CNA) and Dietary voiced she works in the kitchen every once in a while. She reported she checks to be sure the dishwasher temperatures are within the parameters on the Dish Machine Temperature Chart. She usually never documents the dishwasher temperatures. She just gives the temperature ranges to the [NAME] and the [NAME] records the information. The [NAME] will direct them when to start using the three-compartment sink to wash, rinse, and sanitize the dishes. She has never mixed the sanitizer for the three-compartment sink. She reported the last time they used the three-compartment sink was about a month ago when the system was put in. On 11/20/24 at 1:36 PM Staff M, Dietary runs the dishwasher frequently. She does test the dishwasher, but she looks to Staff K and the CDM for guidance. She sticks the test strips in the water then compares to the box to ensure the dishwasher is sanitizing. She disposes of the test strip after she tests the machine. She does not write anything down on the documentation sheet. She would report to the CDM right away, then call maintenance if she had issues with the dishwasher. They use the three-compartment sink when the dishwasher is down. She has only had to do it once and she didn't know how to do it, so she had to have the CDM walk her through mixing the sanitizer. That was about a month ago when maintenance was working on the dishwasher. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/20/24 at 1:45 PM the Maintenance Director reported about a month ago they were converting the dishwasher over to a cold-water disinfection system. He relied heavily on the guy setting up the system. He reported a vendor came out to service the machine on 11/18/24. They serviced the pump as the sanitizer level was too low. They found a line in the back of the machine had blown off and no one noticed it. They bypassed that and upped the level of the sanitizer to where it should be. He couldn't say how long the line had been off of the dishwasher. The machine is computerized so he is surprised there isn't some sort of warning that comes up on the machine. It had to have been in the past week or weekend that the hose popped off. A few weeks ago, staff were complaining there was water leaking on the floor under the dishwasher. He had to come in and change a fitting on the dishwasher and everything was okay at that time. In the past week, maybe last Wednesday, the clear goblet glasses were more cloudy. So that may have indicated a change, but he wasn't putting two and two together at that time. Observation on 11/20/24 at 2:08 PM the CDM ran a test strip through the dishwasher and revealed the test strip at 100 PPM appropriately sanitizing. The CDM reported no one had come to her with any reports the dishwasher was not running correctly so she felt the issue with the line had to have been in the past week or two. Going forward she plans to have the staff document the PPM strip test on the Dish Machine Temperature Chart. She expects if the dishwasher is not sanitizing, the staff will immediately stop use of the dishwasher, report to her and the Maintenance Director and move to using the three-compartment sink system for wash, rinse, and sanitation. The facility lacked a documentation system to ensure prior dishware sanitation in the dishwasher.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on observation, clinical record review, Center for Disease Control and Prevention (CDC) Infection Control Guidance: Sudden Acute Respiratory Syndrome (SARS) COVID 2 Guidelines, COVID 19 Clinical Guidance Summary Review and staff interviews, the facility failed to follow CDC COVID 19 guidance and utilize personal protective equipment (PPE) to prevent the potential spread of COVID 19 affecting 7 of 10 resident in the CCDI (chronic confusion or dementing illness) unit (Resident #4, #10, #13, #25, #21, #36 and #38). The facility reported a census of 37 residents. Findings include: Upon entrance to the facility on [DATE] at 10:00 AM the Administrator reported the facility had 9 residents on isolation for COVID 19. The facility provided a Resident Roster which listed Residents #4, #10, #21 and #36 as positive for COVID 19 in the CCDI unit. Resident #13 tested positive for COVID 19 on 11/19/24. Observation on 11/18/24 at 11:29 AM revealed Resident#21 with an isolation bin outside of her room that contained N95 masks (National Institute for Occupational Safety and Health (NIOSH); an N95 respirator is a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles. Note that the edges of the respirator are designed to form a seal around the nose and mouth) masks, gloves, isolation gowns and a face shield. Resident #21 room contained no signage to indicate any type of isolation precautions or special use of PPE. Further Observation revealed isolation bins outside of Resident #4, #10 and #36 rooms. Resident #4 and #10 lacked signage indicating any type of special precautions or what type of PPE was required for care. Resident #36 had a CDC sign for Enhanced Barrier Precautions (EBP) due to use of a catheter on the top of the isolation bin. No additional signage noted to direct precautions for COVID 19 or any CDC signage on how to properly apply and take off Personal Protective Equipment (PPE). Observation on 11/18/24 at 11:24 AM Staff F, Licensed Practical Nurse (LPN) wearing a medical mask responded to Resident #10 fall alarm. Staff F checked Resident #10 from the open doorway. Resident #10 sat in her recliner not attempting to get up. Staff F applied an isolation gown and gloves to enter into Resident #10 room. Staff F failed to apply an N95 mask and eye protection. Staff F shut off the fall alarm and approached resident within 4 foot of the resident to offer a drink of water. Resident #10 did not wear a mask. At 11:26 AM Staff F removed the isolation gown and gloves to exit Resident #10 room. Staff F failed to change the medical mask when exiting the COVID 19 isolation room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/18/24 at 11:34 AM Resident#4 got out of bed and was up walking in his room. Staff F followed up with resident asking if he had pain. Staff F told Resident #4 she would get his pain cream and be back. At 11:35 AM Staff F performed hand hygiene, donned an isolation gown, gloves, goggles and wore her existing medical mask into Resident #4 room to administer his medication and pain cream. Resident #4 observed not wearing a mask as Staff A stood within a few feet of him administering his medications. Staff F exited Resident #4 room still wearing the same medical mask. Staff F walked to the medication cart and prepared medications for medication pass. At 11:41 AM Staff F approached Resident #38 (COVID negative resident) still wearing the medical mask from the COVID isolation room) sitting within 2 feet of Resident #38. She handed him a glass of water and his medication cup. Staff F touched Resident #38 left wrist to adjust his watch for him. At 11:46 Staff F assisted Resident #38 back to his room to administer his eye drops. She then walked with him out of the room talking to him within 4 feet of the resident still wearing the same medical mask worn into a COVID isolation room. Resident #38 leaned toward Staff F within 2 feet prior to walking along-side the resident. At 11:49 AM Staff F walked along-side Resident #38 around the unit within 2 feet of the resident. At 11:53 AM Staff F assisted Resident #38 to sit down at the dining room table. On 11/18/24 at 11:37 AM Resident #10 set off her chair alarm. Staff F immediately went to the doorway to check on the Resident #10. Resident #10 sat in the room recliner, but did not attempt to get up. Staff F applied an isolation gown, gloves, N95 mask and goggles to enter into Resident #10 room to assist to the bathroom. Resident #10 did not wear a mask. On 11/18/24 11:54 AM Staff G, Certified Nursing Assistant (CNA) assisted Resident #21 (COVID positive; not wearing a mask) from her room approximately 50 feet through the main dining area to the tub room passing within four feet of Resident #38 (negative for COVID 19) who sat at the dining room table. Staff G wore an N95 mask, isolation gown, gloves and eye goggles. The Hospice CNA followed Staff G out of Resident #21 room wearing only a medical mask and gloves following to the tub room. At 11:58 AM Staff G came out of the tub room wearing her full PPE and went past Resident #38 within 4 feet of him sitting at the table and went into Resident #21 room. At 11:59 AM Staff G exited Resident #21 room with her PPE off. Staff G failed to disinfect the goggles when she exited Resident #21 room. At 12:16 PM the Hospice Aide opened the tub room door to ask Staff A, Infection Preventionist for help. The Hospice Aide stood within 6 feet of Resident #21. Resident #21 observed not wearing a mask and the Hospice Aide observed not wearing an isolation gown. At 12:17 PM Staff F applied an isolation gown, gloves, N95 mask and goggles to enter the tub room to assist the Hospice Aide with Resident #21. At 12:19 PM the Hospice Aide assisted Resident #21 out of the shower room in the wheelchair. Resident #21 had not been provided with a mask. The Hospice Aide wore only gloves, a medical mask and goggles at this time. The Hospice Aide wheeled Resident #21 through the dining room within 4 feet of Resident #38 and Resident #25 (COVID negative resident). At 12:21 PM Hospice Aide walked out of Resident #21 room still wearing her gloves, medical mask and goggles. The Hospice Aide removed her gloves right before punching in the code to leave the dementia unit. The Hospice Aide continued to wear the same medical mask out into the main part of the nursing home. On 11/18/24 12:22 PM Staff A was alerted the Hospice Aide left the unit to enter the nursing home area wearing the same medical mask from the COVID isolation room. Staff A reported all the resident up at the main nursing home had already had COVID. When specifically asked by the Surveyor if every resident had COVID 19, Staff A replied, twelve resident had COVID on the other end. Staff A verbalized the Hospice Aide only sees one resident and indicated it wasn't a problem. (continued on next page)

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	165576	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ossian Care Center	114 Fisher Street Ossian, IA 52161

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/18/24 at 2:36 PM Staff H, CNA donned an isolation gown, gloves, goggles, and wore her existing medical mask, then entered Resident #10 room without donning an N95 mask. Staff H directed Resident #10 let's go to the bathroom. At 2:47 PM Staff H came out of Resident #10 room and placed the goggles on top of the isolation bin without sanitizing the goggles. On 11/18/24 at 2:44 PM Staff G verbalized she uses alcohol wipes to sanitize the goggles after use in a COVID 19 isolation room. On 11/19/24 at 7:51 AM the Surveyor entered the unit to see Staff I, Registered Nurse (RN) performing a nasal swab test for COVID 19 for Resident #13 in the lounge area next to the nurses desk wearing a medical mask, gloves and her prescription eye glasses. Resident #38 sat at the dining room table in the lounge. Resident #13 exhibited nasal congestion and a congested cough. Resident #13 sneezed twice after the nasal swabbing with Staff I standing approximately two foot from the resident. The DON stood within four to six feet of Resident #13 wearing only a medical mask and gloves as she instructed Staff I how to complete the COVID test. The DON verbalized due to Resident #13 symptoms they were testing her again today for COVID 19. Staff J stood within 6 foot of Resident #13 wearing only a medical mask. At 7:59 AM the DON instructed Staff J, CNA that Resident #13 likely had COVID 19 and to take her to her room and make her comfortable. Staff J assisted Resident #19 via wheelchair back to her room and assisted to put her call light in reach without performing hand hygiene, donning an N95 mask, isolation gown, gloves or eye protection. Observation at 8:00 AM revealed Staff I entered into Resident #25 room wearing the same medical mask that she used when she tested Resident #13 for COVID 19. Staff I then came out of Resident #25 room and started to put on an isolation gown. The DON informed Staff I Resident #25 was not COVID positive, but she could still wear PPE in the room if she wanted to. Observation on 11/19/24 at 8:09 AM revealed Staff I performed hand hygiene, donned an isolation gown, applied an N95 mask with a medical mask over top and wore her regular prescription eye glasses into Resident #10 room to administer her morning medications. Observation at 8:11 AM revealed plastic goggles with side shields lay on top of the isolation cart outside of Resident #10 room. Resident #10 coughed twice with Staff I within two foot of her during medication administration. At 8:12 AM Staff I exited Resident #10 room after removing her gown and gloves in the room. Staff I came out of the room and removed her dirty mask and donned a new medical mask without performing hand hygiene between the mask change. On 11/19/24 at approximately 8:13 AM the Director of Nursing (DON) asked Staff I about Resident #13 COVID test. Staff I checked the test and reported Resident #13 was positive for COVID 19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/19/24 at 8:15 AM the Director of Nursing (DON) reported she expected staff to wear an N95 mask, isolation gown, gloves, and protective eyewear into a COVID positive isolation room. She reported staff are to use the goggles with side shields which are in the isolation bins. The goggles should be sanitized with the Sani wipes when the staff exit the rooms as they do not have disposable face shields. At 8:18 AM she voiced if a resident is symptomatic, she imagined they should wear full PPE (N95, isolation gown, gloves and eye protection) when testing for COVID 19. She acknowledged that they did not have any signage on Resident #4, #10, #36 room doors to communicate need for PPE and type of precautions. She verbalized they have a communication sheet they use to communicate resident positive for COVID 19 through report, but acknowledged this does not communicate to outside vendors and visitors if precautions are needed. She voiced the vendors or visitors would see the isolation bins and probably know resident were on precautions. She reported she didn't see any of the sanitizing wipes available in the unit to sanitize goggles. Interview on 11/19/24 at 9:36 AM Staff I reported she received in report which residents were positive for COVID 19 without much more direction. She was just told she could wear her (prescription) glasses, a medical mask and gloves for PPE to care for COVID 19 residents. They were not given any direction on sanitizing goggles. She works as needed and was just being honest with her answers. Interview on 11/19/24 9:52 AM Staff J revealed he was taught to wear an N95 mask, isolation gown, gloves and eye protection into a COVID 19 room. Surveyor shared observation that he did not have goggles on early this morning when he came out of Resident #10 room. He stated his goggles had fallen off in the resident's room. He didn't want her to fall so he just kept going and went back to get the goggles later. Observation on 11/19/24 at 8:23 AM the DON instructed Staff I on proper PPE to wear into the COVID isolation rooms, changing masks when exiting a COVID 19 room, performing hand hygiene and sanitizing goggles after use in the COVID 19 isolation rooms. During an interview on 11/20/24 at 1:19 PM the DON reported the facility started the COVID 19 outbreak on 10/29/24. Interview on 11/21/24 at 9:28 AM with the Infection Preventionist revealed she expects staff to follow the posted (CDC) signs to apply and take off PPE. They follow the CDC procedures for applying and removing PPE for COVID 19 isolation. She voiced residents suspected of COVID 19 symptoms should be tested in their rooms and the nurses should wear an N95 mask, isolation gown, gloves and eye protection during the test procedure. The facility has some disposable goggles, but the plastic goggles should be sanitized with the Clorox bleach wipes to disinfect the goggles for three minutes. On 11/21/24 at 9:34 AM Staff H reported she is required to disinfect the goggles after being in a COVID 19 isolation room with alcohol wipes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/21/24 at 9:45 AM the MDS Coordinator reported she had previously been the Infection Control Preventionist and she is still assisting Staff A with infection control as she is new to the position. She reported she expect staff to apply a N95 mask, gown, gloves and eye protection to enter into a COVID 19 isolation room. Staff should remove their PPE as close to the exit door as possible. Once out of the room, staff should perform hand hygiene and apply a new mask. The goggles should be disinfected after use. She reported she likes to use the small disinfectant packets, but couldn't recall the name of the disinfectant. She then said the Sani wipes. She wasn't sure on the length of time the Sani wipes needed to stay wet on the goggles for disinfection, but thought 3-5 minutes. Staff should test residents suspected of COVID 19 in their rooms wearing an N95, isolation gown, gloves and eye protection. On 11/21 24 the Infection Preventionist provided the Iowa Health Care Association Member COVID 19 Clinical Guidance Summary dated August 7, 2023 for review as part of their facility policies/procedures. The Guidance included the intent of the document to provide clinical guidance and best practices for implementing recent CMS changes. CMS recommends the application of Core Principles of COVID 19 Infection Prevention as noted below: a. Hand hygiene with use of alcohol-based hand rub is preferred. b. Face covering or mask (covering mouth and nose) in accordance with CDC guidance. c. Appropriate staff use of PPE. The Guidance further outlined Transmission-Based Precautions: Transmission-based precautions (TBP) should be applied when caring for a resident who has suspected or confirmed COVID 19 infection. Health Care Personnel (HCP) who enter the room of a resident on TBP should adhere to standard precautions, as well as wear a NIOSH-approved respirator (N95), gown, gloves and eye protection (i.e., goggles or face shield that covers the front and sides of the face. Respirators should be used for care provided to a COVID 19 positive resident, as indicated in transmission-based precautions. The Guidance further directed while (COVID) tests are pending, residents with signs and symptoms should be placed into TBP. The Guidance defined close contact as being within six feet of a COVID positive individual for 15 minutes or more within a 24 hours period. Higher-risk exposure is defined as an HCP who had prolonged (15 minutes or more in a 24 hour period) with a person who confirmed positive for COVID 19 and one of the following: a. HCP were not wearing a respirator (or if wearing a face mask, the person with COVID infection was not wearing a cloth mask or facemask). b. HCP was not wearing eye protection if the person with COVID infection was not wearing a cloth mask or facemask. The Testing Safety Considerations specified during specimen collection, facilities must maintain proper infection control and use recommended PPE, which includes a NIOSH-approved N95 or equivalent or higher-level respirator, eye protection, gloves and a gown when collecting specimens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 6/24/24 CDC COVID 19 Infection Control Guidance: SARS-CoV-2 under recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection directs the following: 1. Personal Protective Equipment a. HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). 2. Visitation a. Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy. 3. Environmental Infection Control a. Dedicated medical equipment should be used when caring for a patient with suspected or confirmed SARS-CoV-2 infection. All non-dedicated, non-disposable medical equipment used for that patient should be cleaned and disinfected according to the manufacturer's instructions and facility policies before use on another patient.