

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/17/2025
NAME OF PROVIDER OR SUPPLIER  Oskaloosa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  605 Highway 432 Oskaloosa, IA 52577	

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)
<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>(continued on next page)</p>

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 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, policy review, and staff interview, the facility failed to carry out cardiopulmonary resuscitation(CPR) in accordance with the resident's wishes, and follow the physician's orders for 1 of 1 residents reviewed for cardiopulmonary resuscitation status(Resident #1). The facility failed to correctly identify that Resident #1 desired CPR related to discrepancies in code status listed in multiple locations and a staff member incorrectly reading the resident's chart. Approximately 7 minutes after Resident #1 was last seen alive, the Advanced Registered Nursing Practitioner(ARNP) issued an order to withhold CPR due to the facility staff's delays. The facility staff also lacked knowledge of how to locate the facility's crash cart. This failure resulted in Immediate Jeopardy(IJ) to the health, safety, and security of the resident. The facility reported a census of 76 residents.The State Agency informed the facility of the IJ on [DATE] at 3:35 p.m.The IJ began on [DATE], the day Resident #1 expired. Facility staff removed the Immediate Jeopardy on [DATE] through the following actions:Reeducation of staff regarding the location of resident code statuses and emergency equipment.Placement of a code status book at each nursing station.An audit of resident code statuses.The scope lowered from J to D at the time of the survey after ensuring the facility implemented education and their policy and procedure.Findings included:The Minimum Data Set(MDS) assessment tool, dated [DATE], listed diagnoses for Resident #1 which included heart failure, hemiplegia(one-sided paralysis), and anxiety disorder. The MDSlisted his Brief Interview for Mental Status(BIMS) score as 14 out of 15, indicating intact cognition. Care Plan entries, dated [DATE], directed staff to carry out advance directives per the request of the resident and the family and stated the resident wished to have Staff carry out CPR. The CPR Policy, dated [DATE], stated the resident wished for CPR to be initiated if his heart stopped beating and stated the facility employees would provide basic life support until paramedics arrived. The Physician Order type labeled as advanced directives dated [DATE] directed staff to provide CPR.The [DATE] Medication Administration Record(MAR) listed CPR for the resident's advance directives. The heading on the resident's Electronic Health Record(EHR) listed CPR for the resident's advance directives. A [DATE] Nurses Note stated on [DATE] at approximately 7:45 a.m., Staff A Certified Nursing Assistant(CNA) entered the resident's room followed by Staff C Registered Nurse(RN) and the resident was slumped in his recliner. It appeared the resident was in distress when Staff A and Staff C repositioned him. The resident had an incontinent bowel movement and was diaphoretic(sweating profusely) and unresponsive. Staff C exited the room to obtain assessment tools, summoned the Director of Nursing(DON) to the room, and directed Staff B Licensed Practical Nurse(LPN) to call an ambulance and verify the resident's code status. When the DON arrived, she noted that the resident appeared ashen and diaphoretic and had agonal respirations(abnormal, involuntary gasping for air that indicated a serious medical emergency). The DON checked for a carotid pulse(pulse felt over arteries in the neck) and did not locate one. (Facility Staff) transferred the resident to the floor and the DON opened the resident's airway. Staff C left the room to confirm the resident's code status. Two way radio communication indicated the resident was a No Code per Staff B. Staff were directed to clean and clothe the resident for family viewing. The DON called Staff F ARNP to report the death and Staff F confirmed with the nursing staff(based on Staff B's report) that the resident was a No Code and advised release of the body to the funeral home. During this time, Staff C notified the resident's spouse. While she reviewed the chart, Staff C noted that the resident was listed as a Full Code. She then reviewed the paper chart and confirmed the code status as a Full Code. The DON contacted Staff F to report the discrepancy. Based on assessment findings which included an undetermined time of unresponsiveness, ashen color, mottling,(a pattern of irregular, blotchy discoloration of the skin) and absence of pulse, staff did not initiate resuscitative efforts. On [DATE] at 9:53 a.m., Staff F stated she received a call from the DON (on [DATE]) at 7:51 a.m. The DON reported that Resident #1 was deceased as of 7:49 a.m. Staff F inquired as to the resident's code status and the DON reported he was a Do Not Resuscitate (DNR) and Staff F gave an order to release the body. The DON then called Staff F back at 7:57 a.m. and said that she(the DON) was upset and they were incorrect, the resident was a Full Code. Staff F stated at that time, the resident had been gone for almost 10 minutes so she did not advise them to start CPR from that point. Staff F stated she did not expect to receive a phone call that the resident expired and stated he was not healthy but there was nothing leading up to his death. Staff F stated if a resident was unresponsive, the first thing staff should do was call 911. She stated with regard to Resident #1 staff should have initiated CPR On [DATE] at 10:35 a.m. via phone. Staff F CNA</p>		

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F 0684  Level of Harm - Actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (continued on next page)

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F 0684  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, clinical record review, and facility policy review, the facility failed to carry out timely assessments and interventions after a resident complained of chest pain for 1 of 3 residents reviewed for a change in condition(Resident #9). The facility reported a census of 76 residents.Findings included:The Minimum Data Set(MDS) assessment tool, dated 6/8/25 listed diagnoses for Resident #9 which included hypertension(high blood pressure), nonrhematic aortic stenosis(a condition where the aortic valve, which controls blood flow from the heart to the body, becomes narrowed or obstructed), and weakness and listed her Brief Interview for Mental Status(BIMS) score as 12 out of 15, indicating moderately impaired cognition. The facility policy Clinical Change in Condition, dated 6/2015, directed staff to assess the resident's status when there was a change in condition and to contact the provider. Care Plan entries, dated 6/23/25, stated the resident had altered cardiovascular status related to high blood pressure, a history of cerebrovascular accidents(strokes), and aortic stenosis and stated the resident would be free from complications of cardiac problems through the review date. The Care Plan directed staff to assess for chest pain with every interaction and to enforce the need to call for assistance when the pain started. An 8/5/25 10:13 a.m. Nurses Note, written by Staff B Licensed Practical Nurse(LPN), stated the resident did not appear to have shortness of breath or wheezing, her appetite was good, and (staff) would continue to monitor.An 8/5/25 12:31 p.m. Orders-Administration Note, written by Staff B, stated the resident received 2 puffs of an albuterol(a medication which helped with breathing)inhaler for shortness of breath after dinner and after ambulation. An 8/5/25 1:51 p.m. Nurses Note, written by Staff B, stated the resident slept since dinner time but stated she was short of breath after ambulation. The resident received her albuterol inhaler and her vitals were: temperature 98.1, pulse 93, respiration 16, blood pressure 106/63, oxygen saturation 96%. The resident rested in a recliner and (staff) would continue to monitor. The resident had a good appetite at meals today. The August 2025 Documentation Survey Report v2 report documented on 8/5/25 the resident ate 10% of her breakfast and lunch. A 2:02 p.m. Orders-Administration Note, written by Staff B, stated the resident's albuterol inhaler was effective. The August 2025 Medication Administration Record(MAR) lacked documentation that staff administered acetaminophen(a non-narcotic pain reliever) to the resident on 8/5/25. The facility lacked further assessments of the resident on 8/5/25 between 2:02 p.m. and 6:56 p.m. and lacked documentation of an update given to the provider. An 8/5/25 6:56 p.m. Nurses Note, written by Staff H LPN, stated staff reported the resident was not acting like herself. The Certified Nursing Assistants(CNA's) reported the resident had marked lethargy(a state of feeling tired, sluggish, and lacking energy) for the majority of the day and this increased as the day progressed. The resident did not eat, drink, or void today and did not wake up to take medications this afternoon/evening. The CNAs stated the resident complained of chest pain. The resident was difficult to arouse and responded only to a sternal rub but then immediately closed her eyes again with no further response. Her blood pressure was 168/82. The facility received an order to send the resident to the emergency room for evaluation and treatment. An 8/6/25 2:20 p.m. Nurses Note stated ER Staff reported the resident admitted for abnormal labs which included high troponin(a protein found in the heart muscle which is elevated when there was heart damage). A hospital Emergency Department Provider Note, dated 8/5/25, stated the resident complained of left-sided chest pain and her left chest wall was tender. A Hospital Discharge summary, dated [DATE], stated the resident admitted on [DATE] with chest discomfort and staff felt the resident suffered a myocardial infarction (heart attack). The resident received medications including aspirin and Clopidogrel(a medication used to prevent blood clots) to treat the condition. On 9/10/25 at 9:53 a.m. Staff F Advanced Registered Nurse Practitioner (ARNP) stated there was a situation with Resident #9 when Staff B worked when she needed sent out and more assessment was needed. During a follow-up interview on 9/11/25 at 8:47 a.m., Staff F, ARNP stated Resident #9 had a significant cardiac history but after she moved back to the dementia unit she was fairly stable. She stated she was in the facility (the day the resident subsequently went to the hospital) and Staff B was the resident's nurse. Staff F stated while she was at the facility, she received no updates from Staff B regarding Resident #9. She stated she left the facility for the day and Staff H from the night shift called her and said she wasn't herself. She advised Staff H to send the resident to the emergency room and she had an elevated troponin. Staff F stated after her hospitalization, she was sent to a Hospice house. Staff F found out later that the resident had expressed chest pain throughout the afternoon but Staff B dismissed this. On 9/16/25 at 12:28 p.m. Staff I CNA stated</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>Based on personnel file review, the facility in-service attendance calendar, and staff interview, the facility failed to implement training for multiple topics for 6 of 6 staff reviewed (Staff B, M, N, O, P, Q). The facility reported a census of 76 residents. Findings included: An Employee Face Sheet listed the hire date for Staff B Licensed Practical Nurse (LPN) as 1/8/25. The facility's Hired List By Date listed the following hire dates: Staff O Certified Nursing Assistant (CNA) 4/16/25 Staff P CNA 7/16/25 Staff Q CNA 8/28/25 The facility lacked documentation that new hires Staff B, Staff O, Staff P and Staff Q completed training in Quality Assurance and Performance Improvement (QAPI), compliance and ethics, and infection control upon hire and lacked documentation that non-new hires Staff M CNA and Staff N CNA completed training in QAPI and compliance and ethics on an annual basis. An undated, untitled facility document stated the facility training program was for all departments including new hires and existing staff. The facility Inservice Attendance calendar listed infection control as a topic but did not include QAPI or compliance and ethics. On 9/17/25 at 12:41 p.m., the DON stated she did not see any additional education in the staff's files and stated they would work to building their training program.</p>

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<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>Based on personnel file review, the facility in-service attendance calendar, and staff interview, the facility failed to ensure staff completed training in Quality Assurance and Performance Improvement(QAPI) for 6 of 6 staff reviewed(Staff B,M, N, O, P, Q). The facility reported a census of 76 residents. Findings included: An Employee Face Sheet listed the hire date for Staff B Licensed Practical Nurse(LPN) as 1/8/25. The facility's Hired List By Date listed the following hire dates:Staff O Certified Nursing Assistant(CNA) 4/16/25Staff P CNA 7/16/25Staff Q CNA 8/28/25The facility lacked documentation that new hires Staff B, Staff O, Staff P and Staff Q and non-new hires Staff M and Staff N completed training in Quality Assurance and Performance Improvement(QAPI) upon hire/annually. An undated, untitled facility document stated the facility training program was for all departments including new hires and existing staff. The facility Inservice Attendance calendar did not list QAPI as a training topic. On 9/17/25 at 12:41 p.m., the DON stated she did not see any additional education in the staff's files and stated they would work to building their training program.</p>

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<p>F 0945</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program.</p> <p>Based on personnel file review, the facility in-service attendance calendar, and staff interview, the facility failed to ensure staff completed training in infection control for 4 of 6 staff reviewed (Staff B, O, P, Q). The facility reported a census of 76 residents. Findings included: An Employee Face Sheet listed the hire date for Staff B Licensed Practical Nurse (LPN) as 1/8/25. The facility's Hired List By Date listed the following hire dates: Staff O Certified Nursing Assistant (CNA) 4/16/25, Staff P CNA 7/16/25, Staff Q CNA 8/28/25. The facility lacked documentation that new hires Staff B, Staff O, Staff P and Staff Q completed training in infection control. An undated, untitled facility document stated the facility training program was for all departments including new hires and existing staff. The facility Inservice Attendance calendar listed infection control as a training topic. On 9/17/25 at 12:41 p.m., the DON stated she did not see any additional education in the staff's files and stated they would work to building their training program.</p>

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<p>F 0946</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide training in compliance and ethics.</p> <p>Based on personnel file review, the facility in-service attendance calendar, and staff interview, the facility failed to ensure staff completed training in compliance and ethics for 6 of 6 staff reviewed(Staff B, M, N, O, P, Q). The facility reported a census of 76 residents.Findings included: An Employee Face Sheet listed the hire date for Staff B Licensed Practical Nurse(LPN) as 1/8/25. The facility's Hired List By Date listed the following hire dates:Staff O Certified Nursing Assistant(CNA) 4/16/25Staff P CNA 7/16/25Staff Q CNA 8/28/25The facility lacked documentation that new hires Staff B, Staff O, Staff P and Staff Q and non-new hires Staff M and Staff N completed training in compliance and ethics upon hire/annually. An undated, untitled facility document stated the facility training program was for all departments including new hires and existing staff. The facility Inservice Attendance calendar did not list compliance and ethics as a training topic.On 9/17/25 at 12:41 p.m., the DON stated she did not see any additional education in the staff's files and stated they would work to building their training program.</p>