STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165589	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oskaloosa Care Center	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Record Review (EHR), staff interviews and facility policy review, the facility failed to assess, intervene, and monitor interventions per the facility's Bowel Regulatory Program for four of four residents (Resident #1, #2, #3, and #4) reviewed for increased risk of constipation. The facility reported a census of 82 residents. Findings include Review of facility provided Bowel Regulatory Program Policy stated the following:1. Constipation- individuals are considered constipated if bowel movement (BM) frequency is less than three times per week and/or if straining is experienced with more than 25% of bowel movements.2. A daily Bowel Movement Record must be kept for all dependent residents in order to track regularity and assess need for interventions. All CNAs should document whether or not the residents they provided care for had a BM during their shift by indicating the size (e.g. 0, sm, med, lg.) on the record in the space for the appropriate day. 3. It is the charge nurse's responsibility to look at the BM record each shift and initiate interventions as appropriate. 4. If a resident has not had a significant BM for 3 days, laxative treatment is necessary, per physician order. A stepwise progression of laxative treatment is recommended, Constipation is resolved, management should be moved back to the top of the laxative pyramid. following steps are recommended: a. exercise, fluid and fiberb. Stool softeners (e.g. Milk of Magnesium) once dailyc. Suppository, instill rectally as needed 5. The resident's physician should be notified of any new patterns of constipation in which a previously regular resident has a BM less than three times per week and/or is straining with more than 25% of BMS or a resident with chronic constipation is uncontrolled to the extent of fecal impaction removal. Review of facility provided, Night Shift BM Monitor document, stated Please record all residents who have not had a BM in 2 days. (small don't count unless it is 3 [NAME] a day) and day shift will give MOM (Milk of Magnesia). If resident has not had a BM in 3 days ([NAME] don't count unless it is 3 [NAME] a day), resident will get a suppository. 1. Review of Minimum Data Set (MDS) dated [DATE], revealed Resident #1's Brief Interview for Mental Status score of 4, indicating severely impaired cognition. Resident #1's diagnoses included breast cancer, hypertension, hyperlipidemia, and Non-Alzheimer's Dementia. The MDS documented that the resident required staff assistance with toileting hygiene, and was frequently (2 or more episodes of bowel incontinence, but at least one continent bowel movement) incontinent of bowel and bladder.Review of Bowel Elimination report dated 10/1/25-10/30/25 indicated Resident #1 had ten consecutive days (10/16/25-10/25/25) of no documented BM or 3 small BM in one day. Indicating criteria had been met for regulatory tracking and assessment of need for interventions for Resident #1.Review of Night Shift BM (Bowel Movement) Monitor documents for October 2025, documented Resident #1 on the following days, date of last BM, and interventions provided:10/11/25- last BM 10/7/25, no intervention or nurse signature documented10/12/25- documented no residents to be monitored for not having BM in 2 days. 10/14/25- last BM 10/12/25, BM documented by Resident #1's name. No interventions or nurse signature documented. 10/17/25- last BM 10/14/25, nurse noted, had large BM 10/16/25.10/18/25- last BM 10/14/25, noted large on 10/19, no nurse's signature documented.10/19/25- last BM 10/14/25, no intervention or nurse signature documented.10/21/25- last BM 10/15/25, noted had BM yesterday10/25/25- last BM 10/20/25, suppository administered, effective with large BM.Review of (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's October 2025 Medication Administration Record (MAR) indicated the following medications and administration:a. Milk of Magnesia Suspension 1200mg/15mL. Give 30mL by mouth once daily as needed for constipation, to promote bowel movement. No administration documented. b. Bisacodyl Laxative Suppository 10mg, insert 1 suppository rectally as needed for constipation. Administered on 10/26/25 at 4:46 AM with unknown effectiveness documented. 2. Review of MDS dated [DATE], revealed Resident #2's Brief Interview for Mental Status score of 3, indicating severely impaired cognition. Resident #2's diagnoses included hypertension, Non-Alzheimer's Dementia and history of stroke. The MDS documented that the resident required staff assistance with toileting hygiene, and was occasionally incontinent of bowel.Review of Bowel Elimination report dated 10/1/25-10/30/25 indicated Resident #2 had four consecutive days (10/19/25-10/22/25) of no documented BM or 3 small BM in one day. Indicating criteria had been met for regulatory tracking and assessment of need for interventions for Resident #2 for the following days:Review of Night Shift BM Monitor documents for October 2025, documented Resident #2 on the following days, date of last BM, and interventions provided:10/20/25- last BM 10/18/25, nurse signed and noted MOM administered as intervention.10/23/25- last BM 10/18/25, no intervention or nurse signature documented.Review of Resident #2's October 2025 MAR indicated the following medications and administration:1. Milk of Magnesia Suspension 1200mg/15mL. Give 30mL by mouth once daily as needed for constipation, to promote bowel movement. Administered 10/26/25 at 8:02 AM, effective with large BM. 2. Bisacodyl Laxative Suppository 10mg, insert 1 suppository rectally as needed for constipation. No administration documented. Review of Resident #2's Nursing Progress notes, indicated the following:1. Staff A, Licensed Practical Nurse (LPN) documented on 10/26/25 at 2:51 PM, Staff reported to this nurse that resident vomited two times the shift. upon assessment, resident afebrile, denies any nausea. 10/29/25 at 7:39 AM, progress note stricken out by Staff A, LPN, due to incomplete documentation.2. Staff A, LPN documented on 10/26/25 at 5:25 PM, Resident noted to have multiple emesis throughout the shift which were water like, with one emesis showing food. Resident did have MOM today for constipation, and produced positive results. abdomen non-distended, slightly firm, bowel sounds present x4. Notification left for physician. lemon lime soda and crackers offered, will continue to monitor. 10/29/25 at 7:40 AM, progress note stricken out by Staff A, LPN, due to incomplete documentation.3. Staff B, LPN documented on 10/26/25 at 5:30 PM, This nurse was called into the unit to assess resident, CNAs reported that Resident was throwing up all morning and had been having bowel issues. Resident was given MOM and had good results, but then started to get sick. vitals stable. Phone call placed to provider, received telephone order for Zofran 4 mg every 4 hours. medication was given to resident, resident did vomit up medication several more times. Phone call place to provider again, telephone order received to send resident out to the hospital. phone call was placed to Resident's wife and call to nurse manager on duty. Resident left via ambulance around 6:30 p.m. 4. Staff A, LPN created a Late Entry Nursing Progress Note on 10/29/25 at 7:45 AM, with effective date of 10/26/25 at 8:10 AM, Stated, CNA reported to this nurse that Resident appeared to have stool that he was unable to pass. Upon assessment, abdomen non-distended and slightly firm. Upon palpation, resident does not complain of pain or discomfort. skin warm and dry and normal in color. MOM administered at 8:02 AM will continue to monitor.5. Staff A, LPN created a Late Entry Nursing progress note on 10/29/25 at 8:01 AM, with effective date 10/26/25 at 9:10 AM, at approximately 9:00, this nurse called back unit due to resident produced an emesis. Resident observed sitting upright and common area upon arrival. resident awake and alert with no signs or symptoms of distress noted and emesis appeared to be color and consistency of undigested food of this morning meal. Skin warm and dry and normal color. Abdomen non-distended and continues to be slightly firm, respirations un-labored at 16. Upon assisting resident and CNA to Resident's room for cares, Resident was noted to have a large brown and firm BM possibly as a result of the MOM. resident shows no signs or symptoms of pain or discomfort at this time. This nurse notified staff that she would continue to monitor resident. 6. Staff A, LPN created a Late Entry Nursing progress note on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/29/25 at 8:12 AM, with effective date 10/26/25 at 1:00 PM, Nurse was notified that Resident produced another emesis. Upon arrival to resident, he was observed sitting upright in his room and holding an emesis basin. amount appears to be less than a cup, liquid and yellow and color with no odor. resident awake and alert, with no signs or symptoms of distress. respirations un-labored at 16. abdomen non-distended and continues to be slightly firm with no signs and symptoms of pain or discomfort upon palpitation. 7. Staff A, LPN created a Late Entry Nursing progress note on 10/29/25 at 8:20 AM, with effective date 10/26/25 at 5:30 PM, Nurse was informed that Resident had an emesis. Upon arrival to Resident's room this nurse observed the resident using restroom. Resident awake and alert and shows no signs of distress, pain or discomfort. Emesis light yellow in color, liquid, no odor and about less than a cup. Abdomen non-distended and soft, upon palpitation no signs or symptoms of pain or discomfort. This nurse encouraged staff to offer saltine crackers and clear liquids. vital signs: temp 97.7, pulse 78, respirations 16, blood pressure 145/80. On interview on 10/29/25 at 4:50 PM, Staff C, Director of Nursing (DON) and Staff D, Registered Nurse revealed Resident #2 had been admitted to the hospital for a bowel obstruction. Review of Emergency Department Progress notes dated 10/26/25, Resident #2's diagnosis includes; massive hiatal hernia with associated large bowel obstruction.3. Review of MDS dated [DATE], revealed Resident #3's Brief Interview for Mental Status score of 4, indicating severely impaired cognition. Resident #3's diagnoses included depression and Alzheimer's disease. The MDS documented that the resident required staff assistance with toileting hygiene, and was always continent of bowel.Review of Bowel Elimination report dated 10/1/25-10/30/25 indicated Resident #3 had six consecutive days (10/25/25-10/30/25) of no documented BM or 3 small BM in one day. Indicating criteria had been met for regulatory tracking and assessment of need for interventions for Resident #3.During an interview on 10/30/25 at 11:48 AM, Staff C, DON, stated the provided Night Shift BM Monitor documents for Resident #3 are the only ones she can locate.Review of facility provided Night Shift BM Monitor documents for Resident #3, both dated 10/28/25. One document identified Resident #3's last BM 10/24/25, nurse signed and noted suppository administered as intervention. Second document identified Resident #3's last BM 10/24/25, nurse noted no intervention, medium BM on 10/28/25Review of Resident #3's October 2025 MAR indicated the following medications and administration:a. Milk of Magnesia Suspension 1200mg/15mL. Give 30mL by mouth once daily as needed for constipation, to promote bowel movement. Administered 10/27/25 at 8:00 AM, ineffective results. b. Bisacodyl Laxative Suppository 10mg, insert 1 suppository rectally as needed for constipation. No administration documented. 4. Review of MDS dated [DATE]/25, revealed Resident #4's Brief Interview for Mental Status score of 00, indicating severely impaired cognition. Resident #4's diagnoses included Alzheimer's disease, non-Alzheimer's dementia, seizure disorder, anxiety disorder, depression, psychotic disorder, and hypothyroidism. The MDS documented that the resident required assistance with toileting hygiene.Review of Bowel Elimination report dated 10/1/25-10/30/25 indicated Resident #4 had 5 consecutive days (10/7/25-10/11/25), four consecutive days (10/15/25-10/18/25), four consecutive days (10/22/5-10/28/25) of no documented BM or 3 small BM in one day. Indicating criteria had been met for regulatory tracking and assessment of need for interventions for Resident #4.During an interview on 10/30/25 at 11:48 AM, Staff C, DON, stated the provided Night Shift BM Monitor documents for Resident #4 are the only ones she can locate.Review of Night Shift BM Monitor documents for October 2025, documented Resident #4 on the following days, date of last BM, and interventions provided:10/11/25- last BM 10/6/25, nurse signed and noted MOM administered as intervention.10/12/25- last BM 10/6/25, nurse noted suppository administered as intervention. 10/17/25- last BM 10/15/25, nurse signed and noted MOM administered as intervention.10/18/25- last BM 10/14/25, nurse noted MOM administered with effective results. Review of Resident #4's October 2025 MAR indicated the following medications and administration:a. Milk of Magnesia Suspension 1200mg/15mL. Give 30mL by mouth once daily as needed for constipation, to promote bowel movement. Administered 10/11/25 at 8:06 AM, unknown effectiveness (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented. 10/17/25 at 8:40 AM, effective results. b. Bisacodyl Laxative Suppository 10mg, insert 1 suppository rectally as needed for constipation. No administration documented. In an interview with Staff C, DON on 10/30/25 at 3:55 PM, Staff C, DON acknowledged the Night Shift BM Monitoring is not being done daily and lack of nursing documentation. Staff C, DON stated she would expect nurses to document a nursing note for every resident that is placed on BM Monitoring and complete a GI assessment. These residents will remain on the Hot Charting until the resident has had results or the Physician is notified for further instructions. Staff C, DON stated the facility BM protocol is two days with no BM, MOM is to be given. Three days with no BM a suppository is to be administered. If a resident does not have results from these interventions the Physician must be contacted for direction. Staff C, DON also stated she expected nurses to complete a full head to toe assessment on all residents with changes in symptoms, illnesses to include vomiting. If the resident vomits two times the Physician is to be called immediately to notify and receive further recommendations.