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	04/15/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on clinical record review, interviews, and policy review the facility failed to report a resident to resident altercations involving (R#1) and failed to report allegation of abuse involving (R#5) to the State Agency. The facility reported a census of 75 residents. Findings include:1. The Quarterly Minimum Data Set(MDS) assessment for Resident #1 dated 3/25/26 listed diagnoses included dementia. The Brief Interview for Mental Status (BIMS) assessment scored 3 of 15, indicating severe cognitive deficits. The MDS assessment for Resident #3 dated 3/18/26 listed diagnoses included Alzheimer's disease, anxiety disorder and depression. The BIMS assessment scored 00 of 15 indicating severe cognitive deficits. The MDS assessment for Resident #5 dated 1/7/26 listed diagnosis included cancer, non-Alzheimer's, unspecified dementia with other behavioral disturbances. The BIMS assessment was not completed indicating severe cognitive deficits. A Statement, handwritten dated 1/7/26 signed by Certified Nurse's Aide, (CNA) Staff A documented Resident #5 smacked Resident #3 on the left arm. After the altercation Staff A walked with Resident #5 throughout the unit, Resident #5, then smacked Resident #1 on the arm. Resident #1 raised his arm going towards Resident #5 who was then redirected by Staff A and by CNA, Staff B. In a Written Statement dated 1/7/26, Staff C, Social Services, documented her observations from across the room. Approximately five minutes after Resident #5 slapped Resident #3, Staff C observed Resident #5 tap Resident #1 on his upper body. Staff A and Staff B separated Resident #1 and Resident #5 and made sure Resident #1 wasn't too upset over the altercation. On 4/6/26 at 3:45 PM Staff C, Social Services, stated on 1/7/26 she saw Resident #5 slap Resident #3, then Resident #5 slapped Resident #1. The Director of Nurses (DON) directed Staff C to handle reporting. Staff C used the words slap and tap to describe the contact made by Resident #5, but these contacts were not different, both were with an open hand. On 4/8/26 at 11:45 AM Staff A, CNA relayed witnessing Resident #5 slap Resident #3, then reached over and smacked Resident #1. Both residents were separated. Resident #1 became upset and required redirection about five minutes after being smacked by Resident #5. Staff A reported this to the agency nurse on duty who summoned the Nurse Manager, Staff C. Staff A reported that Staff C gave instructions to write down the altercation between Resident #5 and Resident #3, and not to write about the altercation between Resident #5 and Resident #1, because it didn't happen. Staff A relayed it did happen and Staff B, CNA also saw it happen. (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

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	04/15/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/26 at 12:25 PM Staff B, CNA reported writing a statement on 1/7/26. Staff B stated he had not written about the altercation between Resident #3 and Resident #5, because he didn't witness it. Staff B relayed, he did witness Staff #5 hit Resident #1 and did not document it because Staff D, RN said they were not going forward with reporting that altercation. Staff B stated he was directed not to write a statement involving Resident #5 and #1's altercation and did not. An interview on 4/8/26 at 2:30 PM Staff D, RN, revealed she was directed to the memory care unit by the DON on 1/7/26 at about 4:30 PM to address the altercations, including direction to submit the report to the state agency. Staff D was told by the DON, it is not necessary to address Resident #5 hitting Resident #1 because the video camera didn't show it happened. Staff D relayed she was instructed to submit to the state agency, and did not include the altercation with Resident #5 as was directed. On 4/8/26 at 3:50 PM the DON informed, the state reporting was completed by Staff D on 1/7/26 with DON guidance. The DON was able to recall an altercation between Resident #3 and Resident #5 but did not recall any altercation between Resident #5 and Resident #1. The DON acknowledge the written statements included Resident #5 and Resident #1's altercation and did not recall looking at the camera footage or reporting it had been automatically deleted. A review of the facility policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated October 2022, documented resident-to-resident physical contact that occurs, which includes but is not limited to where residents are hit, slapped, pinched or kicked and results in physical harm pain or mental anguish is considered resident to resident abuse. The facility will presume that instances of abuse cause physical harm, or pain or mental anguish in residents with cognitive and or physical impairments which may result in resident unable to communicate physical harm, pain or mental anguish, in the absence of evidence to the contrary. An example would be a resident slapping another resident who is physically or cognitively impaired even though the resident who was slapped showed no reaction, it is presumed the resident experience pain. Residents must not be subjected to abuse by anyone. All allegations of resident abuse, neglect, exploitation, mistreatment, should be reported immediately to the charge nurse, the charge nurse is responsible for immediately reporting the allegations to the Administrator or designated representative. Resident abuse allegations shall be reported to the State Agency. 2. The Care Plan dated 3/30/26 documented Resident #5's need for assistance of one with dressing and personal hygiene, allowing sufficient time for dressing and undressing due to Resident #5's dementia with behavioral disturbances and confusion. Due to Resident #5's communication problems and anxiety, the Care Plan documented for staff to allow adequate time for Resident #5 to respond and do not rush. During an interview on 4/7/26 at 10:17 AM Staff D, RN revealed on 1/17/26 she was made aware of an incident by the DON. Staff E, CNA had notified the DON she had observed Staff F, CNA, slap Resident #5. The DON informed Staff D, RN that Staff F, CNA would be suspended until the completion of the facility's investigation and Staff F, CNA had denied the incident had occurred. Staff D, RN also reported Staff E, CNA (reported the incident) had to retake her Mandatory Reporter/Dependent Adult Abuse training and was told by the DON she was being dramatic and didn't know what dependent abuse was. A few weeks after the incident Staff D, RN was informed the incident had not been reported to the Iowa Department of Inspections Appeals and Licensing. When Staff D, RN asked the DON about reporting to the state, the DON informed her she didn't feel it needed to be reported. (continued on next page)

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	04/15/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 4/8/26 at 9:36 AM, Staff E, CNA stated Resident #5 is normally calm and wouldn't intentionally hurt anyone but does get scared with cares and brief changes. On 1/16/26 Staff E, CNA and Staff F, CNA were providing care for Resident #5, Resident #5 was scared while Staff F, CNA was being rough with her, telling her what to do, and rushing her. Resident #5 was swinging her arms in an attempt to push away Staff F, CNA and hit her on the back. Staff F, CNA then hit Resident #5 on the right thigh. Staff E, CNA told Staff F, CNA you can't do that, and Staff F, CNA responded it worked didn't it? Staff E, CNA then told Staff F, CNA to leave the room while Staff E, CNA finished Resident #5's cares. After exiting Resident #5's room Staff E, CNA asked that an activities staff stay on the memory care unit, Staff E, CNA then reported the incident to the DON and facility Administrator. Staff E, CNA reported she was yelled at by the DON and facility Administrator being told she was making the facility look bad, overreacting, causing problems, and sometimes we have to overlook things. Staff E, CNA was then sent to the staff breakroom and told by the DON and Administrator to stay there until they had heard back from the state. About thirty minutes later Staff E, CNA was informed by the DON, the State recommended to use this as a learning experience and both Staff E, CNA and Staff F, CNA would retake their Dependent Adult Abuse course online and Staff E, CNA was at fault as well for leaving the unit with Staff F, CNA. Threats of Staff E, CNA losing her certification and even prison time was possible due to her leaving the memory unit while Staff F, CNA would have access to Resident #5 by the DON. On 4/8/26 at 10:04 AM and 10:24 AM, requests for the facility's investigation for the abuse allegations against Resident #5 were requested by State Surveyor. Facility Administrator and DON were not able to recall this incident. During an interview on 4/8/26 at 10:38 AM, DON stated she was not aware of the abuse incident in January for Resident #5. After the DON was informed of the incident by State Surveyor, the DON stated she remembered the incident being referred to. DON stated she was in a meeting, another nurse pulled her out and informed her Staff E, CNA was upset. Staff E, CNA reported to DON that Resident #5 had hit Staff F, CNA and Staff F, CNA hit Resident #5 on the leg. DON recalled, she went to the memory unit and Resident #5 was calm sitting on a chair, instructed Staff F, CNA to leave the unit, then completed a full head to toe assessment of Resident #5 with no findings. The DON continued, after the assessment Staff E, CNA and the Administrator discussed the incident. Staff E, CNA informed them that Staff F, CNA was crouched down in front of Resident #5 as she was sitting, Resident #5 was swinging her arms in attempt to stop Staff F, CNA's assistance hitting Staff F, CNA on the back. Staff F, CNA then smacked Resident #5 on the leg. DON explained during this time, she sat on a chair and asked Staff E, CNA to reenact the incident, Staff E, CNA crouched down in front of DON (as Staff F, CNA had been with Resident #5) and patted DON's right thigh. DON instructed Staff E, CNA to show me how it happened, was there more force? DON was told by Staff E, CNA the slap was more of a pat. DON asked Staff E, CNA, when Staff F, CNA was patting on Resident #5's leg, was this to get her attention? Staff E, CNA then agreed, Staff F, CNA was trying to get Resident #5's attention. DON continued to explain, Staff F, CNA was interviewed about the incident and provided the same scenario as Staff E, CNA. DON acknowledged she did tell Staff E, CNA to use this incident as a learning experience and instructed both CNAs to retake their Dependent Adult Abuse training. The DON acknowledged this incident had not been reported to the state as she didn't feel it was abuse and was not aware of the reporting regulations. During an interview on 4/8/26 at 2:29 PM, Staff F, CNA stated on 1/17/26 she was provided cares for Resident #5, she had been combative, She had hit me like 800 fucking times on the back and the head. Staff F, CNA patted Resident #5's leg and said He Resident #5, can we get you dressed? in an attempt to distract her, which worked. Staff E, CNA then yelled at Staff F, CNA you just hit her, you abuse her, (continued on next page)

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	04/15/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	you can't do that! After Staff F, CNA was instructed to leave the unit while the DON assessed the situation. A short time later, Staff F, CNA, Staff E, CNA, DON and facility Administrator met to talk about the incident when Staff E, CNA told the DON and facility Administrator, I don't think it was abuse, she just patted her leg. Staff F, CNA was assigned to a different hall for the remainder of her shift and had to retake the Dependent Adult Abuse training. Review of Resident #5's Electronic Health Records (EHR) failed to provide documentation of the incident, head to toe assessment, continued monitoring of Resident #5, or notification to Physician and Resident #5's family. Review of facility provided self reports submitted to Iowa Department of Inspections Appeals and Licensing, failed to indicate incident had been reported. Review of facility provided Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated October 2022 stated, Assault of a dependent adult means the commission of any act which is generally intended to cause pain or injury to a dependent adult, or which is generally intended to result in physical contact which would be considered by a reasonable person to be insulting or offensive or any act which is intended to place another in fear of immediate physical contact which will be painful, injurious, insulting, or offensive, coupled with the apparent ability to execute the act. The risk for abuse may increase when a resident exhibits a behavior(s) that may provoke a reaction by staff, residents, or others, such as:a. Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating;b. Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects;c. resistive to care and services. All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. All allegations of Resident abuse shall be reported to Iowa Department of Inspections and Appeals no later than two (2) hours after the allegation is made.

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	04/15/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to provide a thorough investigation into allegations of abuse for 1 of 1 residents (Resident #5) reviewed. The facility reported a census of 75 residents.Findings include:Review of Minimum Data Set (MDS) assessment dated [DATE] for Resident #5 indicated a Brief Interview for Mental Status (BIMS) was not completed, indicating severe cognitive deficiency. Listed diagnoses include, cancer, non-Alzheimer's dementia, and dementia with other behavioral disturbances. Review of Care Plan dated 3/30/26 documented Resident #5's need for assistance of one with dressing and personal hygiene, allowing sufficient time for dressing and undressing due to Resident #5's dementia with behavioral disturbances and confusion. Due to Resident #5's communication problems and anxiety, the Care Plan documented for staff to allow adequate time for Resident #5 to respond and do not rush. During an interview on 4/7/26 at 10:17 AM Staff D, RN revealed on 1/17/26 she was made aware of an incident by the DON. Staff E, CNA had notified the DON she had observed Staff F, CNA, slap Resident #5. The DON informed Staff D, RN that Staff F, CNA would be suspended until the completion of the facility's investigation and Staff F, CNA had denied the incident had occurred. Staff D, RN also reported Staff E, CNA (reported the incident) had to retake her Mandatory Reportor/Dependent Adult Abuse training and was told by the DON she was being dramatic and didn't know what dependent abuse was. A few weeks after the incident Staff D, RN was informed the incident had not been reported to the Iowa Department of Inspections Appeals and Licensing. When Staff D, RN asked the DON about reporting to the state, the DON informed her she didn't feel it needed to be reported. An interview on 4/8/26 at 9:36 AM, Staff E, CNA stated Resident #5 is normally calm and wouldn't intentionally hurt anyone but does get scared with cares and brief changes. On 1/17/26 Staff E, CNA and Staff F, CNA provided care for Resident #5, Resident #5 was scared while Staff F, CNA was rough with her, telling her what to do, and rushing her. Resident #5 swung her arms in an attempt to push away Staff F, CNA and hit her on the back. Staff F, CNA then hit Resident #5 on the right thigh. Staff E, CNA told Staff F, CNA you can't do that, and Staff F, CNA responded it worked didn't it? Staff E, CNA then told Staff F, CNA to leave the room while Staff E, CNA finished Resident #5's cares. After exiting Resident #5's room Staff E, CNA asked that an activities staff stay on the memory care unit, Staff E, CNA then reported the incident to the DON and facility Administrator. Staff E, CNA reported she was yelled at by the DON and facility Administrator being told she was making the facility look bad, overreacting, causing problems, and sometimes we have to overlook things. Staff E, CNA was then sent to the staff breakroom and told by the DON and Administrator to stay there until they had heard back from the state. About thirty minutes later Staff E, CNA was informed by the DON, the State recommended to use this as a learning experience and both Staff E, CNA and Staff F, CNA would retake their Dependent Adult Abuse course online and Staff E, CNA was at fault as well for leaving the unit with Staff F, CNA. Threats of Staff E, CNA losing her certification and even prison time was possible due to her leaving the memory unit while Staff F, CNA would have access to Resident #5 by the DON. On 4/8/26 at 10:04 AM and 10:24 AM, requests for the facility's investigation for the abuse allegations against Resident #5 were requested by State Surveyor. Facility Administrator and DON were not able to recall this incident. During an interview on 4/8/26 at 10:38 AM, DON stated she was not aware of the abuse incident in January for Resident #5. After the DON was informed of the incident by State Surveyor, the DON stated she remembered the incident being referred to. The DON stated she was in a meeting, another nurse pulled her out and informed her Staff E, CNA was upset. Staff E, CNA reported to DON that Resident #5 had hit Staff F, CNA and Staff F, CNA hit Resident #5 on the leg. DON recalled, she went to the memory unit and Resident #5 was calm sitting on a chair, instructed Staff F, CNA to leave the unit, then completed a full head to toe assessment of Resident #5 with no findings. The DON continued, after the assessment Staff E, CNA and the Administrator me to discuss (continued on next page)

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	04/15/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the incident. Staff E, CNA informed them that Staff F, CNA was crouched down in front of Resident #5 as she was sitting, Resident #5 was swinging her arms in attempt to stop Staff F, CNA assistance hitting Staff F, CNA on the back. Staff F, CNA then smacked Resident #5 on the leg. DON explained during this time, she sat on a chair and asked Staff E, CNA to reenact the incident, Staff E, CNA crouched down in front of DON (as Staff F, CNA had been with Resident #5) and patted DON's right thigh. DON instructed Staff E, CNA to show me how it happened, was there more force? DON was told by Staff E, CNA the slap was more of a pat. DON asked Staff E, CNA, when Staff F, CNA was patting on Resident #5's leg, was this to get her attention? Staff E, CNA then agreed, Staff F, CNA was trying to get Resident #5's attention. DON continued to explain, Staff F, CNA was interviewed about the incident and provided the same scenario as Staff E, CNA. DON acknowledged she did tell Staff E, CNA to use this incident as a learning experience and instructed both CNAs to retake their Dependent Adult Abuse training. DON acknowledged this incident had not been reported to the state as she didn't feel it was abuse and was not aware of the reporting regulations. During an interview on 4/8/26 at 2:29 PM, Staff F, CNA stated on 1/17/26 she was provided cares for Resident #5. The Resident had been combative, She had hit me like 800 fucking times on the back and the head. Staff F, CNA patted Resident #5's leg and said He Resident #5, can we get you dressed? in an attempt to distract her, which worked. Staff E, CNA then yelled at Staff F, CNA you just hit her, you abuse her, you can't do that! After Staff F, CNA was instructed to leave the unit while the DON assessed the situation. A short time later, Staff F, CNA, Staff E, CNA, the DON, and the facility Administrator met to talk about the incident when Staff E, CNA told the DON and facility Administrator, I don't think it was abuse, she just patted her leg. Staff F, CNA was assigned to a different hall for the remainder of her shift and had to retake the Dependent Adult Abuse training. Further interview on 4/9/26 at 2:35 PM, DON confirmed no written/documented investigation had been completed and was not able to provide written witness statements, incident reports, or documented nursing assessments for Resident #5. Review of Resident #5's Electronic Health Records (EHR) failed to provide documentation of the incident, head to toe assessment, continued monitoring of Resident #5, or notification to Physician and Resident #5's family. Review of facility provided Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated October 2022 stated, should an incident or suspected incident of Resident abuse be reported or observed the Administrator or his/her designee will designate a member of management to investigate the alleged incident. The Administrator or designee will complete documentation of the allegation of Resident abuse and collect any supporting documents relative to the alleged incident. 1. Review documentation in Resident record (including review of assessment of resident injury)2. Asses the resident for injury if the allegation involves physical or sexual abuse;3. Provide proper notifications to primary care provider, responsible party, etc. 4. Attempt to obtain witness statements (oral and/or written) from all known witnesses.5. If there is physical evidence that can be preserved, attempt to do so, and maintain in a safe location to minimize risk of evidence being tampered with.

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	04/15/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to provide services that met professional standards regarding following physician's treatment orders (Resident #4) and monitoring for adverse reactions to immunizations (Resident #1, #2, #3, #5, #6, #7, #9, #11, #13, #14) for 11 of 13 residents reviewed. The facility reported a census of 75 residents. Findings include:1. Review of Minimum Data Set (MDS) dated [DATE], revealed Resident #4's Brief interview for Mental Status (BIMS) of 14 indicating cognitively intact. Resident #4's diagnoses included, coronary artery disease, kidney failure, pneumonia, seizure disorder, malnutrition, anxiety, depression, chronic obstructive pulmonary disease (COPD), respiratory failure, and dysphagia (difficulty swallowing) requiring a feeding tube for nutrition. Review of Physicians Orders documented an order for Resident #4, percussion vest (wearable machine designed to break up and clear mucus from the lungs), apply everyday at bedtime, Resident must be sitting up in his recliner while he is wearing the vest. Vest to be worn for 15 minutes then removed for aspiration pneumonia. Do not run while tube feeding is running. Review of Nurses Progress Note dated 2/26/26 at 6:26 PM documented Resident #4's percussion vest was not done today due to a miscommunication between nurses and assignments.2. Review of Residents #1, #2, #3, #5, #6, #7, #9, #13, and #14's Electronic Health Record (EHR) documented receiving a vaccine on 2/13/26 during a facility held vaccine clinic administering physician recommended Shingrix (shingles), Pneumonia, COVID, Tdap (tetanus), and/or Flu vaccines. Review of Residents #1, #2, #3, #5, #6, #7, #9, #13, and #14's EHR failed to provide documented nursing notes indicating which vaccine the resident received, location of administration (left or right upper arm), and monitoring of residents for any adverse reactions. 3. Review of Resident #11's EHR-Immunizations indicated receiving pneumonia and COVID vaccine on 2/13/26. Review of Resident #11's Nursing Progress Notes revealed a new order on 2/17/26 at 5:29 PM, Triamcinolone cream, apply to left upper arm topically three times daily for rash and itching for 3 days. Review of Nurses Progress note dated 2/18/26 at 10:24 identified Resident #11's care plan meeting with Resident #11's daughters and facility staff. Resident #11's daughters had question related to nurses not assessing or documenting Resident #11's reaction to the vaccines. A Nurses Progress note for Resident #11, dated 2/18/26 at 10:25 PM documented continued monitoring of left upper arm rash with new order for Triamcinolone cream. Left upper arm continues with red raised rash. In an interview on 4/15/26 1:00 PM, DON stated the vaccines were provided by a contracted pharmacy. This pharmacy reviewed all resident's records to determine recommended immunizations. The facility physician then reviewed these recommendations and agreed with the pharmacy. Resident's and/or Resident's representative is notified of recommendations and consent or declinations was received. On 2/13/26 the pharmacy came to the facility and administered consented immunizations to designated residents. DON acknowledged the failure to document administered immunizations and monitoring for side effects for the residents that received immunizations. Further interview on 4/15/26 at 3:45 PM, DON stated it is expected for nursing staff to document and monitor for any adverse reactions, at least 72 hours after immunizations are administered.Review of facility provided Immunizations Administration Policy dated 3/2015 revealed the following:1. Document the date, time, and injection site on the Medication Administration Record (MAR) and the Immunization Record. 2. If a resident refuses, document refusal and physician notification in the medical record. 3. Monitor for any adverse reactions for 72 hours after giving the vaccine and obtain vital signs daily for 72 hours. 4. Notify the physician of signs and symptoms of adverse reactions and document in the medical record. 5. Administer medication to ease signs and symptoms of reaction as ordered by the physician.

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	04/15/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy the facility staff failed to administer medications correctly related to omission of medications, residents getting the wrong medications, and tube feeding not started timely, for five of five residents reviewed for physicians orders. (Residents #4, 12, 13,14, and 15). The facility reported a census of 75 residents. Findings include: 1. Review of Minimum Data Set (MDS) dated [DATE], revealed Resident #4's Brief interview for Mental Status (BIMS) of 14 indicating cognitively intact. Resident #4's diagnoses included, coronary artery disease, kidney failure, pneumonia, seizure disorder, malnutrition, anxiety, depression, chronic obstructive pulmonary disease (COPD), respiratory failure, and dysphagia (difficulty swallowing) requiring a feeding tube for nutrition. Review of Resident #4's January to March 2026 Medication Administration Records (MAR) failed to indicate the following scheduled medications had not been administered as ordered: 1. 1/14/26 at 5:00 PM, Keppra (seizure medication), water flush, Fluticasone nasal spray, Systane eye drops.2. 1/18/26 at 4:00 PM, Jevity 1.5 (nutrition feeding supplement), water flush, Albuterol nebulizer treatment with pre/post assessments.3. 1/18/26 at 5:00 PM, Fluticasone nasal spray and water flush.4. 2/28/26 at 2:00 PM, Carbidopa-Levodopa (parkinsonism and seizure medication).5. 2/28/26 at 4:00 PM, Jevity 1.5, Albuterol nebulizer treatment with pre/post assessments.6. 2/28/26 at 5:00 PM, Keppra, water flush, Fluticasone nasal spray, Systane eye drops.7. 3/14/26 at 5:00 PM, Keppra, Famotidine, Fluticasone nasal spray, Systane eye drops.8. 3/14/26 at 7:00 PM, Fluconazole. Review of Nursing Incident Note dated 2/26/26 at 5:30 PM, Staff G, Licensed Practical Nurse (LPN) documented, at around 5:00 PM nurse was made aware, Resident #4 had not received his 2:00 PM dose of Carbidop-Levidopa, Jevity feeding had not been started and did not receive his percussion vest treatment. 2. Review of MDS dated [DATE], revealed Resident #12 BIMS of 5, indicating severe cognitive impairment and diagnoses to include cancer, Non-Alzheimer's dementia, COPD, blepharitis of left lower eyelid (chronic inflammation and irritation of eyelid), and senile ectropion of left lower eyelid (outward turning of lower eyelid, causing dry eyes and irritation). Review of Resident #12's Physician Order Summary revealed the following orders:1. Erythromycin Ophthalmic Ointment, instill one application in left eye four times a daily for ectropion of left eye. 2. OcuSoft Lid Scrub Plus External Pad, apply to bilateral eyes topically one time a day for ectropion left eye and dry eyes. 3. Systane Ophthalmic Solution, instill one drop in both eyes two times a day for dry eyes. Review of Nursing Incident Note dated 1/2/26 at 11:10 AM, Staff G, LPN documented, when placing an eye drop in Resident #12's right eye, resident yelled out that it burned. After which this Staff G, LPN looked at the bottle and noted it was ear drops, not eye drops. Immediately flushed resident's eye as much as Resident #12 would allow. 3. Review of MDS dated [DATE], revealed the BIMS assessment was not completed indicating Resident #13's severe cognitive deficits. Resident #13's diagnoses included kidney failure, hypertension, Non-Alzheimer's dementia, and seasonal allergies. Review of Nursing Incident Note dated 12/8/25 at 9:14 AM, Staff G, LPN documented, Resident #13 received another resident's medications by error. Staff G, LPN had prepared medications for a resident and checked the picture on the eMAR, and table seating chart. Staff G then asked a resident if her name was [other resident], in which Resident #13 nodded her head in agreement. Staff G, LPN administered prepared medications for another resident to Resident #13. Review of medications administered to Resident #13 on 12/8/25 in error, included:1. 5 milligrams (mg) Lisinopril (hypertension)2. 50mg Metoprolol ER (hypertension)3. 20 milliequivalents (mEq) Potassium Chloride (low potassium)4. 10mg Buspirone (anxiety)5. 20mg Omeprazole (hearburn)4. Review of MDS dated [DATE] revealed Resident #14 BIMS of 15, indicating cognitively intact. Resident #14's diagnoses included A-fib, heart failure, arthritis, chronic pain, Non-Alzheimer's dementia, anxiety, and depression.Review of December 2025 MAR indicated Resident #14's pain medications, 50 mg Tramadol to be administered twice daily at 8:00 AM and 5:00 PM, extra strength Tylenol 500mg two tablets three times a day at 8:00 AM, 12:00 (continued on next page)

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	04/15/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PM, 8:00 PM, and 200mg Ibuprofen three tablets every eight hours as needed for pain. Review of Nursing Incident Note dated 12/8/26 at 4:11 PM, Staff G, LPN documented failure to administer Resident #14's 8:00 AM Tramadol pain medication, realizing error at 2:25 PM. Staff G, LPN administered as needed ibuprofen to Resident #14 due to second Tramadol dose administration time at 5:00 PM and Resident #14 rating pain 8/10. In an interview on 4/8/26 at 3:15 PM, Staff G, LPN stated she had medication errors, including giving a resident's medications to the wrong person. During an interview on 4/15/26 at 3:30 PM, DON stated she expected nurses and medication aides to use the five rights before administering medications, right patient, right drug, right dose, right route, and right time. Review of facility provided Medication Administration Policy dated 1/2013 stated the following:1. Verify physician's orders for medication to be administered.2. Review any special precautions and perform needed evaluations prior to administering medication to the resident.3. Identify residents.4. Explain the procedure to the resident, including the type of medications ordered, the reason, frequency, and route. 5. Verify the following again, by comparing medication to MAR prior to administering:a. Correct residentb. Correct medicationc. expiration dated. Dose and dosage forme. Routef. time