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	06/11/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, resident interview and policy review, the facility failed to be respectful and provide care with dignity for 1 of 3 residents reviewed (Residents #2). The facility reported a census of 78 residents. Findings included:The Minimum Data Set (MDS) dated [DATE] identified Resident #2 (R2) with Brief Interview for Mental Status score of 15 of 15 indicating is intact cognition. Diagnosis included stroke affected one side. Resident #2 was coded for frequent pain and dependent, needed two or more to assist from chair to bed. The Care Plan revised on 6/9/25 for Resident #2 documented was completely dependent for transferring with the (redacted company name) stand lift and assistance of two staff. The Care Plan also directed to use caution during transfers and is at risk for pain, to anticipate needs. A Progress Note, titled, Incident Note dated 5/11/26 at 5:30PM (Late Entry 5/11/26 10:45AM) documented as follows; that Certified Nurse Aide CNA, Staff F filed a grievance on behalf of Resident #2 who reported was experiencing pain when transferred and CNA, Staff A said to R2 shut your mouth. Resident #2 was directly interviewed by the facility Social Worker. R2 reported to the Social Worker the following events; Staff A transferred R2 with the EZstand transfer device to the bed. R2 yelled out in pain when Staff A moved R2's arm. Staff A, responded You're all right R2 responded It is painful and if there is a noise that needs to get out, I'm going to let it out. Staff A responded Then just keep your mouth shut. R2 responded I can't. Staff A interview statements on 5/11/26 at 1:30PM included the following documentation, Resident A yelled in my ear so Staff A responded, The yelling please you are a bit loud and, can we try and hold it in. Staff A reported that he did not realize the comments hurt R2.An Incident Witness Statement dated 5/11/26 signed by Resident #2 relayed on 5/10/26 at approximately 7:00 PM, Staff A assisted with transfer via the lift alone, and moved Resident #2's injured arm so, he yelled out in pain. Staff A responded you are alright, and said, the noise. Resident #2 responded, it is painful and if there is a noise that needs to get out, he would let it out. Staff A responded, then just keep your mouth shut. An Incident Witness Statement dated 5/11/26 by Staff A relayed, assisted Resident #2 from recliner to bed, Resident #2 yelling out, groaning loudly in my ear and had responded, the yelling please, you are a bit loud, know you hurt but can we try and hold it in . Staff A relayed did not realize the comment hurt him.During an interview on 6/9/26 at 4:37 PM, the DON relayed expectation Is that residents are expected to be treated with respect and dignity and the report by Staff #2 was concerning.During an interview with Resident #2 on 6/9/26 at 2:30 PM, recalled when Staff A transferred from the chair to bed had yelled out and loud, it hurts. Staff A said noise/quiet caused him to be upset and said it can't be helped, it hurt. The CNA said keep your mouth shut it won't come out. During an Interview with Staff A on 6/10/26 at 12:55 PM relayed when transferred Resident #2, caused screaming, he was hurting and responded, was sorry and am almost done, felt no point he was mad or that I said anything wrong. A facility policy titled, Dignity, undated relayed residents to be cared for in a manner that promotes and enhances sense of well-being, level of satisfaction with life and feeling of self-worth and self-esteem, to be treated with dignity and respect at all times.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on clinical record review, staff interviews and policy review the facility failed to ensure 1 of 3 (Resident #1) residents reviewed for transfers was repositioned and kept clean and dry. Resident #1 sat for a prolonged time in a wheel chair without repositioning and with urine-soaked clothing. The facility reported a census of 78 residents. Findings included: The Minimum Data Set (MDS) assessment tool, dated 4/1/26 listed diagnoses for Resident #1 included medically complex conditions, cancer, hip fracture, diabetes, anxiety and depression. The MDS coded urine incontinency, always incontinent of bowel and dependent on transfer to chair bed or toilet. The Brief Interview for Mental Status (BIMS) assessment scored 14 of 15, reflected cognition intact. The Care Plan for Resident #1 initiated 11/17/22 revealed assistance needed for all transfers, assistance of two with a mechanical lift, to use a purple sling. A Progress Note, titled, Incident Note dated 6/8/26 at 3:00 PM for Resident #1 revealed a report was received by Registered Nurse, Staff D at 7:35 AM that Resident #1 was still in her wheel chair, had been there all night, pants were visibly soaked and Resident #1 had slid down, feet were off the wheelchair pedals. Resident #1 relayed, could not recall if was laid down or changed overnight. Resident #1 quired again and relayed, was left in her wheelchair most of the previous day and all night, had not asked anyone to lay her down and could not recall if staff offered to lay her down and had not told staff she did not want to lay down. The Registered Nurse (RN), Staff E responsible for overnight cares relayed had last seen Res #1 in her wheel chair at 8:00 PM on 6/7/26 and did not receive any report that Resident. #1 refused help to bed during the third shift. A Certified Medication Aide (CMA), Staff G relayed had assisted Resident #1 to bed with Certified Nurses Aide (CNA), Staff C on the morning of 6/8/26 and Resident #1 responded, yes had been up in her wheel chair all night. Staff C also relayed saw a dried line on the resident's pants where Residents #1 had wet and was dried. Resident #1 had slid down in the wheel chair and back of pants were very wet, Resident #2 relayed could not recall how long was sitting up. CNA, Staff B, responsible for Resident #2 during the night was interviewed and relayed, saw Resident #1 at 10:30 pm, resident did not want to go to bed, saw resident again in the wheel chair at 1:30 AM and again at 2:20 AM said did let resident know would be back about 3:00 AM as she needed changed, at 3:30 AM assisted resident to bed with Staff H and asked resident if wanted back up to the chair after changing, sat resident back in the wheel chair because she refused offer to stay in bed and went back once more at the end of shift and resident still did not want to go to her bed, instead stayed in the wheelchair. A Licensed Practical Nurse (LPN) Staff I, relayed on 6/7/26, the evening shift saw Resident #1 up was not laid down for the night when most other residents went to bed which was not unusual. CNA, Staff H relayed at 3:30 AM helped Resident #1 into bed changed and asked numerous times if had wanted to be out of the wheelchair and go to bed, refused so changed Resident #1 and put her back in the wheel chair. An incident Witness Statement, dated 6/8/26 at 9:55 AM, CNA, Staff C relayed start of shift in the morning of 6/8/26, received report from Staff B, CNA that Resident #1 refused to lay down last night. Staff C documented that when she saw Resident #1 in her wheel chair she was slouched over, the front of the brief was wet, Staff C laid her down and saw that the brief was soaking the front of the pants. During an Interview on 6/9/26 at 10:40 PM with RN Staff E, confirmed worked the overnight shift 6/8/26 and it was not reported that Resident #1 refused to go to bed or would have intervened, felt resident is easy going and could have persuaded her to lay down. During an interview on 6/9/26 with CNA Staff B at 10:00 PM, relayed first saw Resident #1 at beginning of shift about 10:30 PM in the wheelchair and responded, no one put you to bed and then saw Resident #1 at least four times during the night and resident was good. Staff B relayed. at about 2:20 AM told Resident #1, would be back because, needed to be changed. At 3:30 AM used the lift from wheel chair to bed, changed resident and asked do you want to stay in bed or move back to the wheel chair. Reported Resident #1 wanted to go back to the chair so staff used the lift to get the resident back in the wheel chair. Staff B came back and saw resident one more time at the end of (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shift about 5:15 AM. Staff B relayed checked on residents about four times a shift and is aware repositioning should be every two hours. During an interview on 6/10/26 at 10:40 AM with CNA, Staff G, relayed on 6/ 8/26 about 8:00 AM saw Resident #1 slid down in the wheel chair, and could tell the resident had been wet and then dried, as there was an outline in the front of resident's pants, the back was very wet that was seen when resident was up in the lift. Resident #2 did not know how long she was left up and was not surprising due to resident progressive of cognitive decline. During an interview on 6/10/26 at 11:00 AM, CNA, Staff C relayed during the start of shift on 6/8/26 at 6:00 AM, Staff B reported to me that Resident #1 refused to get into bed during the night. Staff C relayed, normally we do rounds together and didn't that morning and regretted because did not see Resident until about 7:20 AM and Resident #1 was slouched down in the wheel chair. The front of her was soaked, was alarmed when realized how severe this was, felt terrible and emotional that hadn't seen resident sooner. Resident #1 responded she had been in the chair since dinner the night before and is not her norm to stay up, usually likes to lie down. Staff C stated Resident #1 was slanted over, slouched one foot dangling in the middle of the wheel chair, was soaked from front of pants and brief and even the transfer sling was drenched. During an interview on 6/9/26 at 5:15 PM RN, Staff D relayed when saw Resident #2 on 6/8/26 about 7:00 AM, had received report it was unknow how long resident was up in the wheelchair, resident was visibly soaked, assisted Staff C to lye Resident #1 in bed for head-to-toe assessment. Interview attempted with Resident #2 on 6/10/26 at 11:50 AM was not able to recall specifics of episodes over last few days, did not want to relay any further information. On 6/9/26 at 3:50 PM, The DON relayed, the Staff are expected to do walking rounds at shift change and should report resident refusals to nurse included refusals for positioning and or changing of clothes/incontinent cares. The DON relayed residents should be repositioned every couple of hours and change of briefs if neededThe facility provided policies included, Turning and Reposition, directives included to assist resident as needed into proper alignment. The facility document titled Rights and Responsibilities documented the facility to strive to assure that each resident has a dignified existence, self-determination with communication.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, resident interview and policy/competency review, the facility failed to ensure safety precautions for 1 of 3 residents reviewed when used a mechanical lift was used to transferred from chair to bed (Resident #2), Two staff were required to assist the resident transfer when a mechanical lift is used for safety. The facility reported a census of 78 residents.Findings include:The Minimum Data Set, dated [DATE] identified Resident #2 with Brief Interview for Mental Status score of 15 of 15 indicated intact cognition. Diagnosis included stroke affected one side affected. The MDS coded Resident #2 had frequent pain and was dependent for two or more helpers for sit to stand, chair to bed or toilet transfers. The Care Plan focus initiated 6/9/25 for Resident #2 revealed completely dependent for transferring with use of (redacted company name) mechanical lift stand and assist of two staff. A Progress Noted, titled, Incident Report dated 5/11/26 5:30PM relayed grievance report on behalf of Resident #2 related to Certified Nurses Aide (CNA) Staff A who assisted resident #2 to bed, included the description of the pain caused with the transfer and how Staff A responded. The report revealed Resident #2 was put on the stand lift without assistance of a second staff person with transferring the resident#2 to bed.During an Interview with Resident # 2 on 6/9/26 at 2:30 PM relayed has had long term use of the stand lift device, arrived at the facility in 2025 and has had transfer of one person when only aide is available. Recalled when Staff A last used the stand lift alone and experienced a great deal of pain when Staff A moved the injured arm, it hurt bad, yelled out and loud, was upset. Resident#2 reported that he felt staff was not careful and reported the incident. During an interview with DON 6/9/26 4:37 PM The Director of Nurses, (DON) relayed Staff A should not of used the stand lift alone and all staff get checked off on the process when they start employment and periodically throughout, , and was confident all staff are aware of the proper way to use stand lifts. During an interview with Staff A on 6/10/ 26 at 1255 PM relayed was working his usual sixteen-hour shift and at about 7:30 PM Resident #2 wanted to go to bed. The resident was in the recliner and Staff A proceeded to transfer the resident with the stand lift to bed. Staff A relayed he did not have another staff along, was being inpatient, and just did the transfer alone. Staff A relayed, usually if the nurse is not available to help you can get another staff member. The nurse was not available and should have grabbed another person, and did not. The Competency Check off list dated 12/24/25 for Staff A documented lift and transfer training received. Facility policy titled Transfer Techniques directed to review any special precautions or approaches to take when transferring a resident.