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	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oskaloosa Care Center	605 Highway 432 Oskaloosa, IA 52577

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 47582 Based on facility record review and staff interview, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 77 out of 83 residents. The facility incorrectly coded physical restraints were used on 77 residents. The facility reported a census of 83 residents. Findings include: Record review of the facility provided document titled Resident Matrix dated 7/29/24, 1:20 PM, revealed 77 out 83 residents had physical restraints. During an interview on 7/30/24 at 1:35 PM, Staff K, MDS coordinator, stated the facility does not have any residents who were physically restrained and that she was trained through professional courses, Resident Assessment Instrument (RAI) Manual for MDS coding, to code MDS for physical restraints if any facility beds had bed rails. She confirmed that residents were not physically restrained and there were no physician orders for any of the current residents to have physical restraints. After further discussion, Staff K confirmed that MDS's for 77 residents were coded incorrectly. The facility did not produce a requested facility policy for MDS coding throughout the survey week.

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 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** 50500 Based on clinical record review, facility policy review, and staff interview, the facility failed to submit a Level 2 Preadmission Screening and Resident Review (PASARR) evaluation for 1 of 2 residents reviewed with new mental health diagnoses and medication revisions (Resident #53). The facility reported a census of 83. Findings include: The Quarterly Minimal Data Set (MDS) dated [DATE] documented Resident #53 had a Brief Interview for Mental Status (BIMS) of 0 indicating a severe cognitive impairment. Diagnoses on the MDS include anxiety, depression, & psychotic disorder (other than schizophrenia). The MDS reported the use of high-risk medications including an antipsychotic, antianxiety, and antidepressant. The Level I PASARR for Resident #53 was completed on May 13, 2023 and is the last PASARR screening completed. The PASARR documented Resident #53 to have depression/depressive disorder diagnosis with the use of Quetiapine 50 mg (antipsychotic) and Sertraline 150 mg (antidepressant). Review of clinical record for Resident #53 under medical diagnoses reflects the resident had diagnoses of anxiety and depression, both with a date of 5/19/23, and delusional disorder with a date of 6/27/23. Review of clinic record for Resident #53 under orders for medication administration documented the resident received psychotropic medications Quetiapine oral tablet, 25 mg two times day with a revision date of 7/25/24, and Risperidone (antipsychotic) injections, 12.5 mg one time a day every fourteen days with a start date of 8/9/23. Antidepressant medication included Sertraline 100 mg administered as one and a half tabs one time a day with a start date of 5/20/23. Antianxiety medication included Lorazepam .5 mg oral tab, one tab every four hours as needed for anxiety and restlessness with a start date of 1/29/24. Review of the facility policy titled Pre-Admission Screening for MR/MI, dated Feb' 15, directs staff to verify that the appropriate State-designated agency is contacted for any resident/patient requiring a MI/MR Level 2 screen on admission, annually, or upon diagnosis of an MI/MR previously unknown or undetermined. In an interview on 7/31/24 at 9:05 AM, Staff A, social services, verified the last PASARR completed for Resident #53 was May' 23. Staff A explained a Level 2 PASARR was not indicated with new documented diagnoses of anxiety and delusional disorder and the initiation Risperidone and Lorazepam. Staff A explained since there was not a status change, a Level 2 PASARR was not needed. Staff A reported either nursing or the physician would provide updates to medical diagnosis or medications but no formal process in place.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on record review, observations, staff interviews, and policy review, the facility failed to carry out therapy recommendations and provide restorative exercises for 1 of 4 residents reviewed for rehabilitation services and/or limited range of motion (Resident #64). The facility reported a census of 83 residents. Findings include: The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #64 had diagnoses of arthritis, weakness, and a history of falling. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The MDS recorded the resident had impaired range of motion (ROM) to the bilateral upper extremities and to the lower extremity on one side. The MDS indicated the resident required substantial to maximum assistance for moving from sitting on the side of the bed to lying flat in bed, and required partial to moderate assistance for transfers. The MDS documented the resident had occupational therapy (OT) 11/20/23 to 12/11/23, physical therapy (PT) 11/17/23 to 12/12/23, and participated in a restorative nursing program (RNP) for zero (0) days during the 7-day lookback period. The Quarterly MDS assessment dated [DATE] revealed the resident had impaired ROM to the bilateral upper extremities and to the lower extremity on one side. The MDS indicated the resident had dependence on staff for transfers. The MDS documented the resident had no OT or PT, and participated in a restorative program for 0 days during the 7-day look-back period. The Care Plan initiated 3/17/23, and revised 3/4/24, revealed the resident required assistance with exercise for regaining and maintaining her strength, and to maximize her independence for ADLs (activities of daily living). The Care Plan directives for staff included a RNP at least 15 minutes daily which included participation in group exercise, assistance with gait training, ambulation, and transfers, and active range of motion (AROM) and passive range of motion (PROM) to the upper and lower extremities. The care plan also revealed the resident had total dependence on staff for toileting and transfers. The resident required use a mechanical lift and assistance of two staff for transfers. The electronic health record (EHR) revealed the resident had no hospitalization s from 2/15/23 - 7/29/24. A notification from the PT assistant to the physician dated 12/7/23 revealed PT/OT discharge notification and a restorative program established. The restorative exercise program signed by OT on 12/11/23 and PT on 12/12/23 revealed the following exercises recommended 3 to 5 times per week as tolerated: upper and lower extremity AROM, arm bike for 3 minutes, hand gripper 30 pounds (lbs) for 15 minutes x 2 repetitions, seated exercises, thera-band exercises, trunk exercises, bilateral lower extremity stretches x 3 repetitions, and group exercise. The goal for RNP included: maintenance/improvement in ROM, strength, and endurance with ADL's and mobility. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The PT Discharge Summary dated 12/12/23 revealed the resident had osteoarthritis, abnormal gait and mobility, and muscle weakness. The resident required minimum to moderate assistance for transfers during the day and 1-2 staff for transfers in the evening. The resident ambulated less than 20 foot with minimum assistance and use of a gait belt. The therapy recommendations included a restorative activity program. The prognosis to maintain her current level of function was deemed excellent with participation in a RNP and consistent staff follow-through. The RNP could also help reduce her pain with mobility. The EHR progress notes dated 5/17/24 to 7/26/24 revealed a weekly restorative program note. The progress note documented the resident participated in PROM exercises to the upper and lower extremities during the week. The note lacked documentation about the type of exercises or the amount of time the exercises performed. The documentation survey reports revealed the following: a. From 5/1/24 to 5/31/24, the resident attended group exercise on 5/7/24 and had PROM to the upper and lower extremities performed on 5/15/24 and 5/28/24. The resident had 0 days AROM, gait training and ambulation. b. From 6/1/24 to 6/30/24, staff documented the resident had AROM to the upper extremities on 6/26/24, and PROM to the lower extremities on 6/4/24 and 6/26/24. c. From 7/1/24 to 7/28/24: staff documented the resident had AROM to the upper extremities on 7/18/24, PROM to the upper extremities on 7/10/24 and 7/22/24, PROM to the lower extremities on 7/10/24, 7/18/24 and 7/22/24. Observations revealed the following: a. On 7/31/24 at 9:19 AM, Staff C, CNA, wheeled Resident #64 in a wheelchair down the hallway to her room. b. On 7/31/24 at 9:26 AM, Staff D, CNA, and Staff C, CNA, used a mechanical lift and transferred the resident from the wheelchair to a recliner. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 7/31/24 at 9:41 AM, Staff B, Restorative Aide, reported she had worked at the facility since 12/2023. PT and/or OT evaluated each resident and determined which residents needed a restorative program. Therapy gave the restorative aide the resident's restorative program plan regarding the appropriate exercises for the resident. Staff B reported she documented the restorative activities in the EHR, and also wrote a progress notes weekly regarding restorative and the resident's progress. Staff B stated the goal for residents to get restorative exercises at least three times a week, which also included 1:1 exercises, group exercise, and a folding (towel) club. Staff B reported she worked with Resident #64 on PROM to the upper and lower extremities, transfers, AROM with ankle weights, leg lifts, and hand grippers. The resident could be resistive to perform restorative activities due to pain in her shoulders. The resident attended group exercise but often slept through it. Staff B reported when she first started working at the facility, Resident #64 walked 5-10 foot on a good day. She had a lot of pain in her shoulder whenever she used her walker. Staff B stated she was always taught to look for facial cues for pain. Staff B reported the resident attended group exercise but only participated in the ball toss, not the stretches. At the time, Staff B showed the surveyor how she documented restorative activity exercises into the EHR. Staff B reported she didn't know how to show the documentation on the exercises performed in the past several days or months. She could only show the current day's restorative tasks and how she entered the amount of time and the exercise activities done. During an interview 8/1/24 at 11:00 AM, Staff E, physical therapist, reported Mod A on the PT discharge summary meant moderate assistance. Staff E reported she filled out a form whenever a resident completed therapy and made recommendations for a restorative program. Staff E stated Resident #64 ambulated at the time she discharged from therapy services in 12/2023. PT also screened Resident #64 in 3/2024 because she had a decline, and staff reported concerns it was not safe to transfer her. They downgraded her to use a Hoyer for transfers. During an interview 8/1/24 at 11:05 AM, Staff F, Licensed Practical Nurse (LPN) reported she took care of Resident #64, including when the resident first admitted to the facility, and most recently on 7/29/24. The resident ambulated when she took care of her in 12/2023. However, when she took care of her on 7/29/24, she noticed the resident no longer ambulated and she requires assistance of two staff for ADL's and a Hoyer used for transfers. Staff F reported the resident had had a significant decline. During an interview 8/1/24 at 12:25 PM, the Director of Nursing (DON) reported therapy made recommendations for a restorative program when the resident completed therapy services. Therapy then gave her a form regarding the RNP program activities to do. The facility's Restorative Nursing policy dated 5/2014 revealed the facility strived to attain and maintain the residents' highest practicable level of physical and psychosocial functioning. Assisting the resident to attain and/or maintain joint mobility promoted their independence, prevented or reduced contractures, stimulated circulation, and enhanced muscle strength. The restorative program activities documented in the resident's medical record, including actual number of minutes the resident participated, as well as when the resident refused to participate in the RNP.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49990 Based on direct observation, staff interview, and family interview, the facility failed to provide sufficient staff to provide needed cares and supervision to ensure safety of residents at the facility. The facility reported a census of 83 residents with 10 of those residents in the Chronic Confusion or Dementing Illness Unit (CCDI). Findings include: 1. A direct observation on 07/30/24 at 10:54 AM of the CCDI unit revealed only one staff, Staff G a Certified Nurses Aide (CNA), on the floor. A direct observation on 07/30/24 at 11:26 AM of a call for request for feeding assistance in another Unit. Staff H, CNA, left Unit to get spoons and returned only briefly, stating she needed to go help feed another unit. This left just one CNA, Staff G, in the unit. Ten residents began dining shortly after 11:30 AM, with all being served by 11:43 AM, with Staff G attempting to supervise all residents during dining services. During the observation Resident #66 made repeated attempts to stand and ambulate away from the dining table without the use of her front wheeled walker. Minimum Data Sample (MDS) for Resident #66 indicated a brief interview for mental status (BIMS) score of 3, indicating severe cognitive impairment and she required a front wheeled walker for safety while ambulating. The Care plan, last updated on 07/11/24, documented Resident #66 was at risk for falls due to dementia, delusions, and impaired mobility. It further documented Resident #66 required one-on-one assistance from staff as needed. Further direct observation on 07/30/24 at 11:26 AM revealed another resident, Resident #53 standing and attempting to leave the dining table without the use of her Merry [NAME] while Staff G was attempting to deal with Resident #66. A review of Resident #53's MDS documented a BIMS score of 00, indicating the BIMS interview could not be completed because the resident is rarely or never understood. It revealed pertinent diagnoses of unspecified dementia and muscle weakness. It documented her daily use of a Merry-Walker for mobility. The resident's care plan, last updated on 07/11/24, documented her use of the merry walker for safety with direct supervision. It further documented the resident was at risk for falls and required one-on-one assistance from staff as needed. A direct observation concurrent with the two observations above revealed a third resident, Resident #12, attempting to walk into another resident's room. While attempting to deal with all three residents experiencing wandering behavior, Staff G frequently did not have eyes on the tables to monitor residents as they ate. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/30/24 at 12:10 PM Staff G stated CCDI is often the first place they pull from when other units are needing assistance. She stated the second CNA, Staff H, had been pulled from the unit to assist elsewhere, leaving her to attempt to supervise all ten residents while they ate and experienced behaviors. She stated she does not believe the facility should pull staff from the CCDI unit as resident behaviors are often unpredictable, and it prevents her from providing one-on-one support when needed in emergent situations until backup staff has arrived. She stated she did not feel comfortable supervising the unit alone during meal times. The second CNA returned to the unit at 12:15 PM after a call for assistance was placed at 12:12 PM due to worsening wandering behaviors. In an interview on 07/30/24 at 12:56 PM with Staff H, she stated she has brought up staffing concerns to administration in the past and often gets the same answer, that they cannot promise not to take staff from CCDI. She does not feel one staff can safely supervise residents during meal times. She stated she is pulled at least twice a day to help with meal times, leaving just one CNA in the CCDI unit to monitor and care for all ten residents. She noted she had been pulled up to five times in a single day for periods of time lasting longer than 30 minutes. In an interview on 08/01/24 at 09:38 AM with Staff J, CNA, she stated when she worked the CCDI unit a staff member was pulled from the unit every single day. She does not believe one person can adequately support the residents in the CCDI unit given their unpredictable behaviors. She feels it slows response time and prevents her from implementing one-on-one support as soon as it is needed. She stated she believed the CCDI required a second staff member at all times for resident safety. A direct observation on 07/31/24 at 08:31 AM revealed only one CNA, Staff G, supervising all residents again. Resident #66, Resident #53, and Resident #12 were all experiencing wandering behavior, requiring significant attention. A second staff member walked into the unit at 09:00 AM. A follow up interview on 07/31/24 at 08:40 AM with Staff G revealed that the second CNA, Staff H, had been pulled from the unit again to assist with breakfast elsewhere. She reiterated that CCDI is the first place that facility leadership pulls staff from when they are working short staffed. A direct observation on 08/01/24 revealed that Staff H was alone on the unit again. A conversation with Staff H at 10:27 AM noted she had been alone since 06:00 AM when her shift started. She stated nurse leadership almost never directly works the floor when CCDI is working short. She noted she was alone unless she called for backup or a nurse came to pass medication. She stated it could take considerable time to get someone into the CCDI unit when she called for backup. She stated she has been told in the past to do what she can because they did not have enough staff to send her backup. She reiterated she does not feel this is safe for residents. She was finally relieved by a second staff at 10:32 AM. In an interview on 07/29/24 at 1:40 PM a staff family member stated that his only real concern with the facility is that they don't have enough staff in the CCDI unit. He feels the cares in CCDI are too difficult with just one staff. When asked how often the unit has just one staff member he stated more than half the days of the week they are even working short. He feels this has contributed to incidents involving his family member. In an interview on 08/01/24 at 11:35 AM with the Director of Nursing (DON), she stated the expectation is to always have two staff in CCDI. She noted it is their goal to have six CNAs working the general facility and two CNAs working in CCDI. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident Care Plan documentation revealed that 5 of 5 residents in CCDI reviewed required one-on-one supervision as needed (R #66, #23, #52, #53, #47). 34817 In a confidential resident interview on 7/29/24 at 2:55 PM, a resident reported he didn't think the facility had enough staff. The resident reported he required use of a Hoyer mechanical lift and two staff whenever staff transferred him. It took a long time for staff to respond and assist with the transfer because no one from the other areas could come. The facility only had one aide staffed on the hall where he resided. Call light observation on 8/1/24 AM at 7:30 AM revealed: room [ROOM NUMBER]A call light on for 30 minutes room [ROOM NUMBER]A call light on for 18 minutes The Call Light Report emailed from the administrator to the surveyors on 8/1/24 at 10:02 AM, revealed call light response times greater than 15 minutes on the following: 31 times on 7/29/24; the longest response time was 1 hour and 26 minutes (recorded at 6:05 AM). 24 times on 7/30/24; the longest response time was 1 hour and 4 minutes (recorded at 6:28 PM) 24 times on 7/31/24; the longest response time recorded was 53 minutes (recorded at 6:36 PM) During an interview on 8/1/24 at 9:30 AM, the Maintenance Supervisor reported they only had the capability to run call light reports for the past 72 hours. The facility's undated call light policy revealed the call light system is an essential tool for residents to request assistance from staff promptly to ensure the safety and well-being of the resident. Staff shall respond to call lights promptly, ideally within 15 minutes. The supervisor monitored call light response times. Call light reports purged within 72 hours.