

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Oskaloosa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 605 Highway 432 Oskaloosa, IA 52577	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and policy review, the facility failed to limit a PRN (as needed) psychotropic drug (drugs that affect a person's mental state) to 14 days and failed to ensure the resident had an appropriate diagnosis for the psychotropic drug for 1 of 6 residents reviewed (Resident #28). The facility reported a census of 81 residents.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #28 scored 13 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The resident did not have a diagnosis of anxiety and did not have physical, verbal or other behavioral symptoms directed towards others and scored a 0 on the resident mood interview (PHQ-2, Patient Health Questionnaire) which indicated no depression or minimal depression symptoms. The resident received an antianxiety medication during the 7 day look back period.</p> <p>The Electronic Health Record (EHR) lacked a diagnosis of anxiety or other mood disorders for Resident #28.</p> <p>The EHR (February 2025 Medication Administration Record) for Resident #28 included an order for Lorazepam (medication to treat anxiety disorders) oral tablet 0.5 mg (milligrams), give 1 tablet by mouth every 4 hours as needed for anxiety, not to exceed 3 doses per 24 hour period, with a start date of 2/19/25 and a discontinue date of 3/15/25. The Medication Administration Record (MAR) for the month of February and March revealed Lorazepam was administered to the resident 7 of the 10 days in February and 11 of the 15 days in March.</p> <p>The EHR for Resident #28 included an order for Lorazepam oral tablet 0.5 mg, given 1 tablet by mouth every 4 hours as needed for anxiety, not to exceed 5 doses per 24 hour period, with a start date of 3/15/25 and a discontinue date of 5/15/25. The MAR for the months of March, April and May revealed Lorazepam was administered to the resident 17 of the 17 days in March, 30 of the 30 days in April and 15 of the 15 days in May.</p> <p>The EHR for Resident #28 included an order for Lorazepam oral tablet 0.5 mg, give 1 tablet by mouth every 4 hours as needed for anxiety, with a start date of 5/15/25 and no end date. The MAR for the months of May and June revealed Lorazepam was administered to the resident 17 of the 17 days in May and 19 of the 19 days so far in June.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The EHR for Resident #28 included a Pharmacist Medication Regimen Review (MRR) dated 2/19/25, recommending the facility review this resident's PRN Lorazepam under the 14 day rule for PRN psychotropic's, be sure that it is discontinued, or evaluated and given a stop date. The EHR lacked a response by the facility to the MRR.</p> <p>The EHR for Resident #28 included a Pharmacist MRR dated 5/16/25, referencing the MRR dated 2/19/25 for the PRN Lorazepam 14 day rule, with a recommendation status from the facility as no response.</p> <p>During an interview 6/19/25 at 1:00 PM the Director of Nursing (DON) acknowledged the facility did not respond to the pharmacy recommendations regarding the PRN Lorazepam for Resident #28 and acknowledged the resident did not have an appropriate diagnosis for the anti-anxiety medication. The DON stated the resident became anxious when she had difficulty breathing and would request the Lorazepam.</p> <p>During an interview 6/19/25 at 1:44 PM the Administrator stated an expectation PRN psychotropic medications not exceed the initial 14 days without a rationale to extend the medication by the physician. The Administrator further stated an expectation the resident should have an appropriate diagnosis for the psychotropic medication.</p> <p>Review of the facility Medication Regimen Review policy, undated, documented the MRR will be completed by a consultant pharmacist and the DON will forward to the physician the MRR findings that require their response.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and policy review, the facility failed to develop and implement a comprehensive person centered Care Plan for 1 of 19 residents reviewed for Care Plans (Resident #28). The facility reported a census of 81 residents.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #28 scored 13 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The resident had diagnoses to include debility, cardiorespiratory conditions, heart failure, asthma and respiratory failure. The resident did not have any psychiatric/mood disorder diagnoses. The resident received an anti-anxiety medication during the 7 day look back period.</p> <p>The EHR (February 2025 Medication Administration Record) for Resident #28 included an order for Lorazepam (medication to treat anxiety disorders) oral tablet 0.5 mg (milligrams), give 1 tablet by mouth every 4 hours as needed for anxiety, with a start date of 2/19/25. This medication continued through June of 2025, as a PRN for anxiety, given to the resident daily since March.</p> <p>The Care Plan for Resident #28, with an initiation date of 1/14/25, lacked a focus area, goal and interventions for anti-anxiety medication and behavior monitoring for the use of the anti-anxiety medication and possible side effect monitoring.</p> <p>During an interview 6/19/25 at 1:15 PM the Assistant Director of Nursing (ADON) acknowledged the Care Plan for Resident #28 did not include a focus area, goal or interventions/tasks related to the resident being on an anti-anxiety medication and stated an expectation this should be in the care plan.</p> <p>During an interview 6/19/25 at 1:44 PM the Administrator stated an expectation the Care Plan for Resident #28 include a focus area, goal and interventions/tasks related to the resident being on an anti-anxiety medication.</p> <p>Review of the facility Clinical Care Management policy, dated 5/2014, documented clinical care management includes routine assessment, evaluation and response to changes in clinical condition and update the care plan as indicated.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews record review and policy the facility failed to follow professional standards during medication administration observation, left medications with a resident, unsupervised administration for 1 of 7 observed (R#45). The facility reported a census of 81.</p> <p>Findings include:</p> <p>The Quarterly Minimum Data Set (MDS) dated [DATE] documented the diagnoses for Resident #45 included progressive neurological conditions, Parkinson's disease, heart disease and depression. The resident's Brief Interview for Mental Status (BIMS) score was 15 of 15 indicated cognition intact.</p> <p>The Care Plan focus dated 1/4/24 revealed Resident #45 had a physician's order for unsupervised self administration of the following medications: muscle rub. The goals to demonstrate the ability, interventions included to assess resident's ability to safely self-administer medications, to discuss medications with each supervised administration, to demonstrate, monitor, provide written documentation on each medication for resident to keep at the bedside.</p> <p>In an interview on 6/18/25 at 8:23 AM, Licensed Practical Nurse (LPN), Staff A, voiced resident is approved for self-administration of medications, had an order, can leave medications at the table for resident self administration, would return to ensure was taken.</p> <p>Observation on 6/18/25 at 8:25 AM, LPN, Staff A placed nine (9) pills for Resident #45 into a medication cup included:</p> <ol style="list-style-type: none"> 1. Carbidopa/Levodopa 25-100 milligram (mg) 2. Carvedilol 6.25 mg 3. Gabapentin 100 mg 4. Losartan pot 25 mg 5. Aspirin 81 mg 6. Multivitamin tablet 7. Vitamin B complex 8. Vitamin E 400 units 9. Calcium 1200 mg with Vitamin D3 <p>Observation 6/18/25 at 8:30 AM, LPN, Staff A proceeded to the main dining room and placed the medication cup with pills in front of Resident #45 who sat at the dining room table with two other residents. LPN, Staff A, left and returned to the medication cart in another hallway.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 6/18/25 at 12:30 PM, Resident #45's responsible party visited, relayed Resident #45 relied on staff for giving medications, is no orders for self-administration of pills, felt that would not be allowed.</p> <p>On 6/19/25 at 12:15 PM, Registered Nurse (RN), Staff B, relayed the Care Plan outlined self administration of medication, muscle rub. Resident #45 had a locked box in the room however, had not been able to use the cream independently, felt processes for independent use was left in place since offered resident a sense of security.</p> <p>On 6/19/25 at 1:00 PM, The Administrator voiced no medications should ever be left unattended, would be a risk for another resident to take, acknowledged Resident #45 medications should of been witnessed by the nurse to ensure took appropriately.</p> <p>The facility policy titled, Medication Administration dates 1/2013 documented procedure included to remain with the resident until all medication is taken.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, staff interviews, record review and policy review, the facility failed to ensure open items were dated, covered and labeled and food was stored under sanitary conditions to prevent cross contamination. The facility further failed to test twice daily the dishwasher to ensure the low temperature dishwasher was getting to the correct temperatures and chemical solution to appropriately sanitize dishes. The facility reported a census of 81 residents.</p> <p>Findings include:</p> <p>During a continuous observation 6/16/25 beginning at 10:45 AM of the pantry and refrigerator with the Dietary Manager (DM) present revealed the following:</p> <ol style="list-style-type: none"> 1. Open, undated bag of graham cracker crumbs. 2. Open, undated bag of powered sugar. 3. Open, undated bag of quick rise soft roll mix. 4. Open bag of muffin mix, with an opened date of February 2025. 5. A full pan of frozen shredded pork thawing in the refrigerator on a shelf above a shelf of eggs. <p>A record review of the dishwasher temperature and sanitization chemical strip test log maintained by the facility revealed several dates missing in the previous three months. In the month of March 2025, there were 18 days that did not have documentation for the temperature and chemical test strip test of the dishwasher. In the month of April, 2025, there were 8 days and in the month of May there were 18 days. An observed test of the low chemical dishwasher completed on 6/16/25 at 11:00 AM revealed appropriate temperatures and chemical solution.</p> <p>During an interview 6/16/25 at 10:55 AM, the DM stated an expectation thawing meat should not be placed above other food items in the refrigerator and acknowledged the pan of thawing meat was placed above a shelf of eggs. The DM stated an expectation food should be dated when opened and used within a short time of the open date. The DM stated an expectation the dishwasher temperature and chemical sanitizer test strip should be conducted and documented daily, both on the AM shift and the PM shift and acknowledged this had not taken place for several days in the past three months. The DM stated she had provided education to staff.</p> <p>During an interview 6/18/25 at 1:38 PM, the Administrator stated an expectation thawing meat should be on the bottom shelf with no other food below it and an expectation food that has been opened have an open date and thrown away if not consumed within a short time. The dishwasher temperature and chemical checks should be completed twice daily and documented.</p> <p>A review of the facility Sanitation and Food Production policy, dated 6/15, documented foods are thawed properly to prevent food borne illness and frozen meats placed on the lowest shelves in the refrigerator to prevent juices from dripping onto other foods and causing cross contamination.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility Food Labeling Reference Guide policy, dated 6/2015, documented when food item is opened and not completely used, write the open date on the food container and a use by date on the food container. Mixes should be used within 7 days of the open date.</p> <p>A review of the facility Dish Machine/Sanitizer Log policy, dated 6/2015, documented to monitor and record once a shift the sanitizing concentration for low temperature dish machine.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on direct observation, clinical record review, staff interview, and facility policy review, the facility failed to perform perineal care for incontinent residents in a hygienic manner for 3 of 3 residents observed (Resident #1, #38, and #63). The facility reported a census of 81.</p> <p>Findings include:</p> <p>1. The Annual Minimum Data Set (MDS) for Resident #1, dated 11/27/2024, documented the resident incontinent and was fully dependent on staff members for toileting hygiene and incontinence care.</p> <p>The care plan for Resident #1, last revised 06/18/2025, also documented the resident was fully dependent on staff members for toileting and hygiene.</p> <p>During a direct observation on 06/18/2025 at 10:25 am, revealed Staff C, Certified Nurse's Aide (CNA), and Staff D, CNA, performing perineal cares and toileting hygiene for Resident #1. During the cleaning of the resident, both Staff C and Staff D disposed of the gloves they were using during cares and continued to provide cares and help the resident dress, making direct ungloved contact with the resident's buttocks.</p> <p>2. The MDS for Resident #38, dated 06/11/2025, documented the resident was incontinent and fully dependent upon staff for perineal cares and toileting hygiene.</p> <p>The care plan for Resident #38, last revised 03/31/2025, documented the resident was dependent on staff for hygiene and required staff assistance to use the toilet.</p> <p>During a direct observation on 06/18/2025 at 11:36 AM, Staff E, CNA, was observed performing perineal cares for Resident #38. During cares a privacy curtain was not fully closed and Staff E used gloves soiled with what appeared to be feces to close the curtains before continuing to clean the resident. After cleaning the resident's perineal area, Staff E removed the gloves and continued to help the resident dress, making bare skinned contact with the resident. Hand hygiene was not performed after removing the gloves and making contact with the resident.</p> <p>3. The MDS for Resident #63, dated 04/23/2025, documented the resident was always incontinent and was dependent on staff for toileting hygiene.</p> <p>The care plan for Resident #63, last revised 04/28/2025, documented the resident was fully dependent on staff for perineal cares and toileting hygiene.</p> <p>During a direct observation on 06/18/2025 at 12:23 PM, Staff C, CNA, took off her gloves during perineal cares and continued to provide care for Resident #63 without gloves, making bare skin contact with the resident's perineal area and groin.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/19/2025 at 03:32 PM with Staff F, CNA, she stated gloves are essential when performing perineal care and hygiene cares on a resident. She stated there is no way she would ever place a clean adult brief on a resident without gloves. She also stated the perineal care checklist states CNAs are to wear gloves during every step of the perineal care process.</p> <p>In an interview on 06/19/2025 at 03:16 PM, Staff G, Licensed Practical Nurse (LPN), stated that during perineal cares she is instructed to wear gloves during the entire process.</p> <p>In an interview on 06/18/2025 at 12:39 PM with the Director of Nursing (DON), she immediately acknowledged the bare skin contact of Staff C with Resident #63 was inappropriate, as she was witness to the perineal care process for that resident. She stated all staff members need to be wearing gloves at all times.</p> <p>A policy regarding perineal cares was requested but not provided during the survey process.</p>