Citation Numb #5492	er:			Date: Decem	ber 27, 2019	
Facility Name: Northern Maha	aska Specialty Care	-	Survey Dates: 10/20/21-12/9/21			
Facility Address/City/State/Zip			10/20/21-12/9/21			
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58.28(3)e	 481—58.28(135C) Safety. The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III) 58.28(3) <i>Resident safety.</i> e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III) 	1	\$6,750.00 (Held in suspension)	UPON RECEIPT
	DESCRIPTION:			
	Based on observations, staff and resident interviews and clinical record review, the facility failed to provide supervision to ensure that 6 female residents of the facility were free from sexual advances from 2 male residents identified in the sample allowing opportunities for exploitation of female residents. Female residents, (Resident #2, #13, #15, #17, #19 and #22) were identified as having been groped and/or propositioned by Resident #1 and/or Resident #18. The interventions put in to place after the incidents were either non-existent or ineffective and did not prevent Resident #1 from groping and or propositioning female residents. These interventions included 15 minute checks which were not done consistently; an alarm placed in Resident #1's doorway that quit sounding after a few seconds, did not alert staff that it had sounded after it quit sounding and could not be heard consistently by staff; and no interventions put into place			

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0		1	n	
	after staff reported incidents of a sexual nature toward			
	female residents. These situations constituted Immediate			
	Jeopardy to residents' health and safety. The facility failed			
	to ensure stand lifts were in proper functioning order or			
	had the appropriate sling available resulting in falls that			
	occurred during transfers for 2 of 3 residents reviewed,			
	(Resident #6, #3). The facility identified a census of 77			
	residents. 53 of the 77 residents were women.			
	Findings include:			
	1. A Minimum Data Set (MDS) with an Assessment			
	Reference Date (ARD) of 8/4/21, documented Resident #1's			
	diagnoses included non-Alzheimer's dementia, cerebral			
	infarction, and renal insufficiency. This resident's Brief			
	Interview for Mental Status (BIMS) score was 7 indicating			
	severe cognitive impairment. Resident #1 was			
	independent with bed mobility, transfers, and walking in			
	room. A Care Plan for Resident #1 included the following			
	focus areas and directed staff to do the following			
	interventions:			
	a. A focus area with a revision date of 8/8/21, documented			
	Resident #1 had an emotional and physical			
	relationship with Peer Resident #8 and was comfortable			
	with physical affection of hugging and kissing and was			
	comfortable with saying no or being told no and stopping if			
	any further progression makes them uncomfortable. The			
	goals revised on 8/4/21, documented Resident #1 would be			
	free from physical/emotional contact with Resident #9			
	that would make Resident #1 uncomfortable. Resident #1			
	would be able to tell Resident #9 no if he was			
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	uncomfortable with physical contact. Interventions with a		
	date initiated on 7/5/19, directed staff to conduct an		
	additional assessment of understanding of consent if		
	changes in mental status or behavioral difficulties are		
	demonstrated and to monitor Resident #1's ability to		
	accurately identify and express type of emotional and		
	physical consensual contact ongoing. An intervention		
	revised on 8/18//21, directed staff to provide privacy for		
	Resident #1 and Resident #8 as needed and to direct them		
	to Resident #8"s room as to not disrupt Resident #1's		
	roommate.		
	b. A focus area revised on 3/4/21, documented Resident #1		
	enjoyed visiting with peers and Resident #1 refused to		
	social distance during activities. His goal was documented		
	he would engage in self-directed leisure pursuits,		
	watching TV and reading the newspaper. An intervention		
	dated 3/4/21, directed staff to provide education to		
	resident regarding social distancing. An intervention dated		
	11/12/18, directed staff to respect Resident #1's decisions		
	for self-directed leisure pursuits. An intervention revised on		
	7/18/19, directed staff to support his self-determination		
	in activities of choice which included that he sometimes		
	liked to walk around the facility.		
	c. A focus area revised on 11/20/18, documented Resident		
	#1 was at risk for decline in ADL (Activities of Daily		
	Living) function related to diagnoses which included		
	dementia, aphasia (a comprehension and communication		
	(reading, speaking, or writing disorder resulting from		
	damage or injury to the specific area in the brain), and		
	possible medication side effects. The goal revised on		
	10/27/21, was for Resident #1 to participate in part of his		
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ADLs. Interventions dated 11/20/18, directed staff to give				
Resident #1 verbal cures to help prompt him and that				
Resident #1 was independent with transfers and				
ambulation in the facility without the need of assistive				
devices.				
d. A focus area revised on 9/20/21 documented Resident				
#1 had a history of acting out with physical and verbal				
comments and actions of a sexual nature towards residents				
and staff when he had an untreated infection. It				
documented as a reminder when he was in the community				
he had been a very affectionate person which included				
hand holding, arm pats, and kissing on the top of the head.				
This resident's goal was to have fewer episodes of				
inappropriate comments toward female staff. Interventions				
dated as initiated on 10/18/21 directed staff that resident				
was started on celexa on 5/28/21 to help control sexual				
urges, resident was started on Depakote on 9/16/21 to help				
reduce sexual urges and directed staff that resident's				
depakote was increased on 9/18/21 to help with sexual				
urges. An intervention initiated on 9/20/21 directed staff				
on 9/18/21 this resident would sit with staff at the nurses				
station for all meals. A resolved intervention dated 9/18/21				
had directed staff this resident had a sensor pad in his				
doorway to alert staff when he was out in the public area.				
An intervention revised on 10/18/21, directed staff the				
sensor pad had been removed and a doorway sensor had				
been added on 10/4/21. An intervention revised on				
11/25/19 directed staff to assist this resident to develop				
more appropriate methods of coping and interacting, to				
provide him with one on one education on appropriate vs				
inappropriate comments towards staff. This intervention				
	Resident #1 verbal cures to help prompt him and that Resident #1 was independent with transfers and ambulation in the facility without the need of assistive devices. d. A focus area revised on 9/20/21 documented Resident #1 had a history of acting out with physical and verbal comments and actions of a sexual nature towards residents and staff when he had an untreated infection. It documented as a reminder when he was in the community he had been a very affectionate person which included hand holding, arm pats, and kissing on the top of the head. This resident's goal was to have fewer episodes of inappropriate comments toward female staff. Interventions dated as initiated on 10/18/21 directed staff that resident was started on celexa on 5/28/21 to help control sexual urges, resident was started on Depakote on 9/16/21 to help reduce sexual urges and directed staff that resident's depakote was increased on 9/18/21 to help with sexual urges. An intervention initiated on 9/20/21 directed staff on 9/18/21 this resident would sit with staff at the nurses station for all meals. A resolved intervention dated 9/18/21 had directed staff this resident had a sensor pad in his doorway to alert staff when he was out in the public area. An intervention revised on 10/18/21, directed staff the sensor pad had been removed and a doorway sensor had been added on 10/4/21. An intervention revised on 11/25/19 directed staff to assist this resident to develop more appropriate methods of coping and interacting, to provide him with one on one education on appropriate vs	Resident #1 verbal cures to help prompt him and that Resident #1 was independent with transfers and ambulation in the facility without the need of assistive devices. d. A focus area revised on 9/20/21 documented Resident #1 had a history of acting out with physical and verbal comments and actions of a sexual nature towards residents and staff when he had an untreated infection. 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An intervention revised on 11/25/19 directed staff to assist this resident to develop more appropriate methods of coping and interacting, to provide him with one on one education on appropriate vs	Resident #1 verbal cures to help prompt him and that Resident #1 was independent with transfers and ambulation in the facility without the need of assistive devices. d. A focus area revised on 9/20/21 documented Resident #1 had a history of acting out with physical and verbal comments and actions of a sexual nature towards residents and staff when he had an untreated infection. It documented as a reminder when he was in the community he had been a very affectionate person which included hand holding, arm pats, and kissing on the top of the head. This resident's goal was to have fewer episodes of inappropriate comments toward female staff. 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	gave an example to staff of you look nice today versus you			
	look sexy today. This intervention directed staff to			
	encourage him to express his feelings appropriately. An			
	intervention dated 8/4/21, directed staff this resident sees			
	meditellie as needed to assist with his behaviors. An			
	intervention dated 11/25/19, directed staff to remove this			
	resident from public area when behavior is disruptive and			
	unacceptable. An intervention dated 7/5/19, directed staff			
	to notify PCP (primary care provider) for an infection			
	workup if this resident displayed increasing sexual based			
	actions towards staff.			
	e. A focus area revised on 7/1/19, documented Resident #1			
	had impaired cognitive function/dementia or impaired			
	thought processed related to diagnosis of dementia and			
	history of CVA (cerebrovascular accident). This resident's			
	goals revised on 8/4/21, were to remain oriented to person			
	and town through the review date and to be able to			
	communicate basic needs on a daily basis through review			
	date. An intervention revised on 11/14/18, directed staff to			
	use his preferred name, identify themselves at each			
	interaction, face resident when speaking and make eye			
	contact, reduce distractions, and that resident understood			
	consistent, simple and directive sentences. Staff were to			
	provide him with necessary cues and to stop and return if			
	this resident was agitated. An intervention dated 11/8/18,			
	directed staff to provide cues, re-orient and supervise as			
	needed.			
	f. A focus area revised on 11/13/18, documented resident			
	had difficulty recalling recent events related to history			
	of CVA and diagnosis of dementia. This resident's goal			
	revised on 8/4/21, was Resident #1 would be able to find			
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2401 Crestvie Oskaloosa, I		MW/DC				
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	remind this resident what for him and to validate hi got confused or anxious. g. A focus area revised on resident was at risk of un- of elopement. This reside and was his safety would date. Interventions dated monitoring device was pla- when he left the building wandering, if the wander escapist, if he was looking exercise and to intervene revised on 11/25/19 direct wanderguard. An undated list of Residen provided by the facility. T follows: 7/1/19 Emotional/Physica was care planned and cor 5/28/21 Resident started 9/6/21 Touched Resident on Resident #13's door to entering room. The reside 9/16/21 Resident started day). 9/18/21 Resident touched	aced on him that sounded alarms and to identify patterns of ing was purposeful, aimless or g for something, did he need more as appropriate. An intervention cted staff that he had a ht #1's current interventions was he interventions were listed as al relationship with Resident #8 hsents were obtained. al relationship with Resident #9 hsents were obtained. Celexa. #13's breast. Stop sign was placed o prevent other resident from				

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Rule or Code Section	Natur	e of Violation	Class	Fine A	Amount	Correction date
α	n II			u U		0
	increased to 500 mg BID. 10/4/21 A sensory pad wa alarm removed. 10/17/21 Resident #1 was with her in his lap. Reside checks were initiated. Resident #1's Progress No * On 2/9/21 at 1:16 p.m., inappropriate statements (Resident #15). Resident # her preference and was m * On 5/20/21 at 5:30 p.m. stated Resident #1 had go room and kissed her on he wanted to file a complain * On 5/21/21 at 3:01 a.m. room resting in bed with a attempts to go into other contact with other resider * On 5/27/21 at 7:05 p.m. collected and dropped off * On 5/28/21 at 11:00 a.m. documented she was info Resident #1 and Resident some point in the past bu documented she spoke to knock before entering any	, a visitor approached staff and one into his wife's (Resident #19) er lips. The visitor stated he t. , the resident had been in his eyes closed . He did not make any residents rooms or make physical				

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* On 5/28/21 at 1:42 p.m., the wife was okay to resume		
Celexa after a long discussion with the Nurse and Social		
Worker about resident's behavior. The doctor was in the		
building and was okay with resuming.		
* On 5/28/21 at 1:45 p.m., the UA was back from review by		
the doctor and was clean. No new orders were obtained.		
* On 6/3/21 at 3:58 p.m., the POA (Power of Attorney) was		
phoned in order to update on Celexa . The family		
wanted a UA due to change in behavior. UA was obtained		
and the results were negative.		
* On 7/19/21 at 11:08 a.m., Resident #1 had a tele		
psychiatric visit with PhD therapist. They discussed the		
recent		
incident he had with a CNA (Certified Nurse Aide) and that		
is important for him to remain sexually appropriate at all		
times.		
* On 7/20/21 at 4:44 p.m., A CNA reported to the Nurse		
that Resident #1 attempted to kiss her. The CNA stepped		
away from the resident and did not welcome his advances.		
The CNA was instructed to take another staff person into		
the room with her.		
* On 9/6/21 at 3:00 p.m., it was reported to the Nurse that		
Resident #1 had gone up behind another resident		
(Resident #13) and touched her breasts. When this was		
reported Resident #1 had already ambulated back to his		
room.		
* On 9/7/21 at 10:35 a.m., the Social Service Coordinator		
met with Resident #1 about the incident that had occurred		
over the weekend. The Social Service Coordinator did the		
sexual consent willing and stated he did not recall		
touching a female's breast.		
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If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to lowa Code section 135C.43A (2013).

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	* On 9/10/21 at 4:04 a.m., monitoring for sexual behaviors		
	and there were no behaviors that shift. Resident was		
	about the facility per his usual without incidents.		
	* On 9/16/21 at 3:47 p.m., new order for Depakote 250 mg		
	BID mood stabilizer.		
	* On 9/18/21 at 9:59 a.m., a female resident (Resident #17)		
	was sitting in lounge when Resident #1 walked up to her		
	and then began talking to her. He then went to the front of		
	her wheelchair and then put his hand down her shirt and		
	touched her breast. Resident immediately removed from		
	the lounge and taken to the nurses station.		
	* On 9/18/21 at 10:09 a.m., Doctor notified of incident.		
	Obtained an order to increase the Depakote to 500 mg BID.		
	The Nurse discussed with Administrator and a 5 Minute		
	Meeting out to staff for resident to stay at nurse's station		
	while awake and alarm in doorway at night time. Spouse		
	was called and notified of new orders, incident and alarm.		
	* On 9/19/21 at 3:12 a.m., Resident #1 remained on		
	increased Depakote. Resident had no memory of incident		
	with female resident. He was able to leave his room		
	undetected due to being able to step over alarm pad in		
	doorway.		
	* On 9/20/21 at 2:17 a.m., Resident stepped on pad in		
	doorway triggering the alarm at that time. The writer noted		
	resident standing by his door only wearing underwear.		
	When resident was approached it was noted he had the		
	alarm in his hand attempting to turn it off. Writer		
	requested the alarm, resident handed it over and the writer		
	reset the alarm.		
	* On 9/20/21 at 9:31 a.m., Resident monitored for new		
	order to increase Depakote. Resident to be at nurses		
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Rule or Code Section	Natur	e of Violation	Class	Fine Am	ount	Correction date
	alarm on in doorway at ni Resident was eating at nu * On 9/20/21 at 11:27 a.m met with Resident #1 and another woman. Resident his wife. Resident #1 was woman there (at the facili no. * On 10/3/21 at 3:55 p.m. Manager regarding alarm Nurse witnessed the resid without setting it off. It was Resident #2 was seen put alarm and trying to step of Resident #1's room before hazard and intervention n intervention is ineffective whereabouts as Resident without setting it off. * On 10/5/21 at 5:35 a.m. circumvent alarm at his do nurses station twice this s Alarm was on when check * On10/17/21 at 2:15 p.m resident's (Resident #2) do was sitting in recliner with #1 had his hand up Resider	h., the Social Service Coordinator asked about him touching #1 stated he had only touched asked if he ever touched a ity) on her breast and he stated , the Nurse notified the Nurse in the resident's doorway. The lent sort of hopping over alarm as also reported to the Nurse that ting her walker over the mat and ver it. Resident #2 made it into e she was redirected. This is a fall eeds to be reevaluated as the for monitoring Resident #1's #1 can easily navigate around it , Resident #1 continues to porway. Resident has been up to hift and alarm did not sound. ted. a., A CNA opened door to por to pass ice and Resident #1 n Resident #2 on his lap. Resident ent #2's shirt. CNA told Resident # be in there and told Resident #2				

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Resident #1 said he would not leave. CNA told Nurse. The		
Nurse stated she was walking down the hall and CNA		
explained situation to her. Nurse entered the room and saw		
Resident #1 sitting in Resident #2's recliner and Resident		
#2 sitting on her bed. Nurse had Resident #1 get up and go		
back into his room and then notified the Nurse Manager.		
The Nurse Manager had Nurse bring Resident #1 up to		
nurses station to keep the residents apart and then notified		
the Administrator and their Nurse Consultant. 15 minute		
checks were initiated. Administrator reporting incident and		
Doctor was notified. Resident' #1's wife was called without		
answer. Spouse returned call and was notified at 7:30		
a.m. on 10/18.		
* On 10/24/21 at 11:51 a.m., Resident #1 continues on 15		
minute checks due to history of entering other residents'		
rooms, attempts to touch a woman inappropriately.		
Resident has had no behaviors of this sort in the last 3 days.		
Resident pleasant and cooperative. Ambulates with a front		
wheeled walker from his room to the lobby area. He has		
made no attempts of going any other places than these 2		
areas. Continues to sit near nurse's station for meals.		
Resident denies any concerns with this. Affect continues		
flat. Speaks when spoken to. Denies any pain or any needs		
at that time.		
* On 11/7/21 at 9:02 a.m., Resident continues on one to		
one supervision and 15 minute checks. Resident noted to		
be more touchy and trying to get close to female staff. One		
to one CNA came to this Nurse to report this. Resident was		
reminded to stay away from female residents.		
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:				Date: Decemi	oer 27, 2019	
a Specialty Care				<u> </u>		
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Drive 577	MW/DC					
Natur	e of Violation	Class	Fine A	Mount	Correction date	
he following 15 Minute (he facility: 10/17/21 4 p.m. to 10/1 ninute checks were initia 10/18(21) and 10/19(21 hecks starting at 3:15 p.r in 10/18/21. It then show .m. to 3:45 a.m. 10/20/21 9:30 a.m. to 3 10/20/21 from 4:00 p.m nitialed. 10/21/21 from 9:30 a.m 10/22/21 from 12:15 a.r vere initialed. Then from hecks were initialed. On esumed at 8:30 p.m. to 1 vritten next to the 8:30 p 0 top of this page the da y the 12:15 a.m. slot 10/ 10/23/21 from 12:15 a.r :30 p.m. and from 6:00 p hecks were initialed. 10/24/21 from 12:15 a.r vere initialed.	was put on 15 minute checks. Checks sheets were provided by 8/21 at 9:15 a.m.: showed 15 led as done)(overnight): showed initialed n. to 3:45 p.m. and at 11:50 p.m. ved initialed checks from 12:05 :45 p.m., all spots initialed. a. to 10/21/21 9:15 a.m. all spots . to 3:45 p.m. all spots initialed. a. to 12:00 a.m. on 10/22/21. m. to 11:30 a.m. showed checks 2 p.m. to 8:00 p.m. showed this sheet it shows checks were 1:45 p.m., however the date .m. slot documented 10/23 (21). te 10/23/21 is written however 22(21) is written. m. to 6:00 a.m., from 2:00 p.m. to .m. to 11:45 p.m. showed m. to 12:00 p.m. showed checks					
	A Specialty Care City/State/Zip Drive 577 Nature . note for Incident # 2264 ocumented Resident #1 he following 15 Minute (note for Incident # 2264 ocumented Resident #1 he following 15 Minute (ne facility: 10/17/21 4 p.m. to 10/1 ninute checks were initia 10/18(21) and 10/19(21 hecks starting at 3:15 p.r n 10/18/21. It then show .m. to 3:45 a.m. 10/20/21 9:30 a.m. to 3 10/20/21 from 4:00 p.m nitialed. 10/21/21 from 9:30 a.m. 10/22/21 from 12:15 a.r vere initialed. Then from hecks were initialed. On esumed at 8:30 p.m. to 1 vritten next to the 8:30 p on top of this page the da y the 12:15 a.m. slot 10/ 10/23/21 from 12:15 a.r :30 p.m. and from 6:00 p hecks were initialed. 10/24/21 from 12:15 a.r vere initialed.	a Specialty Care City/State/Zip Drive 577 MW/DC Nature of Violation Image: Colspan="2">Nature of Violation Image: Colspan="2">Image: Colspan="2">Image: Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Image: Colspan="2">Image: Colspan="2" Image: Colspan="2"	as Specialty Care Survey I City/State/Zip 10/20/21 prive MW/DC S77 MW/DC Class Nature of Violation Class note for Incident # 2264 dated 10/17/21 at 2:15 p.m., ocumented Resident #1 was put on 15 minute checks. he following 15 Minute Checks sheets were provided by he facility: 10/17/21 4 p.m. to 10/18/21 at 9:15 a.m.: showed 15 ininute checks were initialed as done 10/17/21 4 p.m. to 10/18/21 at 9:15 a.m.: showed 15 ininute checks were initialed as done 10/18/21 at 3:15 p.m. to 3:45 p.m. and at 11:50 p.m. n 10/18/21. It then showed initialed checks from 12:05 .m. to 3:45 p.m. and at 11:50 p.m. n 10/20/21 from 4:00 p.m. to 10/21/21 9:15 a.m. all spots initialed. 10/20/21 from 9:30 a.m. to 3:45 p.m., all spots initialed. 10/21/21 from 9:30 a.m. to 3:45 p.m., all spots initialed. 10/21/21 from 9:30 a.m. to 11:30 a.m. showed checks rere initialed. Then from 2 p.m. to 8:00 p.m. showed checks were initialed. On this sheet it shows checks were essumed at 8:30 p.m. sol 10/22/21 is written however the date ritten next to the 8:30 p.m. sol 10/23/21 is written. 10/23/21 from 12:15 a.m. to 12:00 p.m. showed checks were initialed. 10/23/21 from 12:15 a.m. to 12:00 p.m. showed checks were initialed. <td and="" colsp.m.="" from<="" th=""><th>Survey Dates: 10/20/21-12/9/21 Drive 577 MW/DC Fine A Nature of Violation Class Fine A Nature of Violation Class Fine A Class <</th><th>Decemination is a Specialty Care Survey Dates: 10/20/21-12/9/21 City/State/Zip MW/DC Prive 577 MW/DC Fine Amount Invite of Violation Nature of Violation Invite of Violation Inviteon Atth</th></td>	<th>Survey Dates: 10/20/21-12/9/21 Drive 577 MW/DC Fine A Nature of Violation Class Fine A Nature of Violation Class Fine A Class <</th> <th>Decemination is a Specialty Care Survey Dates: 10/20/21-12/9/21 City/State/Zip MW/DC Prive 577 MW/DC Fine Amount Invite of Violation Nature of Violation Invite of Violation Inviteon Atth</th>	Survey Dates: 10/20/21-12/9/21 Drive 577 MW/DC Fine A Nature of Violation Class Fine A Nature of Violation Class Fine A Class <	Decemination is a Specialty Care Survey Dates: 10/20/21-12/9/21 City/State/Zip MW/DC Prive 577 MW/DC Fine Amount Invite of Violation Nature of Violation Invite of Violation Inviteon Atth

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If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Num #5492	ber:				Date: Decemb	per 27, 2019
Facility Name Northern Mar	e: naska Specialty Care		Survey			
Facility Addre	ess/City/State/Zip		10/20/21	-12/5/21		
2401 Crestvie Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	e of Violation	Class	Fine A	mount	Correction date
	 were initialed. No further sheets were produring the missing times. The Clinical Census printer documented Resident #1 room #210 and stayed in finto room #201 on 10/21/ #217 on 10/28/21. 2. A MDS with an ARD of #2's diagnoses included un behavioral disturbance, and resident's Brief Interview was 9 indicating moderater #2 was independent with and required supervision A Care Plan for Resident #2 dementia, depression, po The goals revised on 2/10 would remain oriented to period. Interventions with directed staff Resident #2 fondle her, her family is a seeks out Resident #1 for 	nxiety, and depression. This for Mental Status (BIMS) score e cognitive impairment. Resident transfers, and walking in room for bed mobility. 2 included the following focuses ne following interventions:				

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If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Numb #5492	er:			Date: Decem	ber 27, 2019	
Facility Name: Northern Maha	iska Specialty Care			Survey Dates: 10/20/21-12/9/21		
Facility Addres	ss/City/State/Zip	10/20/21-12/9/21				
2401 Crestview Drive Oskaloosa, IA 52577		MW/DC	-			
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date	

directed staff to provide Resident #2 with diversional		
activities as allowed, to re-orient/re-direct her as she would		
allow and to validate her thoughts/feelings when she		
exhibited frustration related to impairment.		
b. A focus area revised on 9/26/21, documented Resident		
#2 used safety devices and she had a wander guard. The		
goal for Resident #2 dated 9/26/21, was resident would		
remain safe in her environment. An intervention dated		
9/26/21, directed staff Resident #2 had a wander guard.		
c. A focus area revised on 11/25/19, documented Resident		
#2 displayed socially disruptive behavior and would		
on occasion take items that belong to her roommate.		
Resident #2's goal revised on 2/10/21, was Resident #2		
would decrease her episodes of disruptive behaviors by		
50%. Interventions dated 11/26/19, directed staff to visit		
with her and provide diversional activities, to monitor and		
document her behavior, and to talk with her in a calm voice		
when her behavior is disruptive.		
d. A focus area revised on 8/4/21, documented Resident #2		
exhibited signs of disorganized thinking and		
irrelevant conversation. The goal for Resident #2 dated		
8/4/21, was Resident #2's symptoms of delirium would		
resolve without lasting effects. An intervention dated		
8/4/21, directed staff to report any changes in her level of		
consciousness to the doctor.		
A Progress Note dated 10/17/21 at 2:15 p.m., documented		
a CNA opened Resident #2's door to her room to pass ice		
and Resident #1 was sitting in Resident #2's recliner with		
Resident #2 on his lap. Resident #1's hand was up		
Resident #2 of this tap. Resident #1 5 fland was up		
		Dogo 14 of 11

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Facility Administrator

Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Numb #5492	er:			Date: Decem	ber 27, 2019	
Facility Name: Northern Maha	ska Specialty Care			Survey Dates: 10/20/21-12/9/21		
Facility Addres	ss/City/State/Zip					
2401 Crestview Drive		MW/DC				
Oskaloosa, IA	52577					
Rule or		μ		Fine Amount	Correction	
Code	Natur	e of Violation	Class		date	
Section						

	Resident #2's shirt. CNA reported she told Resident #1 he		
	was not supposed to be in there and told Resident #2 to		
	she needed to get out of his lap. Resident #2 moved to the		
	bed. The CNA told Resident #1 to leave and Resident #1		
	said he would not leave. The CNA then notified the Nurse.		
	The Nurse stated she was walking down the hall and the		
	CNA explained the situation to her. The Nurse stated she		
	entered the room and saw Resident #1 sitting in Resident #		
	2's recliner with Resident #2 walking to her bed. Nurse		
	stated she had Resident #1 get up and go back to his room.		
	The Nurse then went to the nurse's station and notified the		
	Nurse Manager. The Nurse brought Resident to the		
	nurse's station to keep the resident's apart. The Nurse		
	Manager then notified the Administrator, and the Nurse		
	Consultant. New BIMS assessment was completed with a		
	BIMS of 5 (severe cognitive impairment). Fifteen minute		
	checks were initiated. Administrator was reporting incident		
	and the doctor was notified. Resident #2's son was		
	called and notified of the incident.		
	A note for Incident # 2264 dated 10/17/21 at 2:15 p.m.,		
	documented resident was put on 15 minute checks for 24		
	hours.		
	The following 15 Minute Checks sheets were provided by		
	the facility:		
	* 10/17/21 4 p.m. to 10/18/21 at 9:15 a.m.: showed 15		
	minute checks were initialed as done.		
	* 10/18/21 at 9:30 a.m. to 3:45 p.m., showed 15 minute		
	checks were initialed as done.		
	No further sheets were provided.		
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Facility Administrator

Citation Number: #5492					Date: Deceml	oer 27, 2019
	haska Specialty Care	-	Survey 10/20/21			
Facility Addr	ress/City/State/Zip			-		
2401 Crestvi Oskaloosa, I		MW/DC				
Rule or Code Section	Natur	e of Violation				Correction date
	 documented Resident #2 400 hall to room #211 in f 3. A MDS with an ARD of # 15's diagnoses included respiratory failure with hy #15's BIMS score was 15 in Resident #15 was independent and walking in room. A Care Plan for Resident # area and directed staff to a. A focus area dated11/2 used safety devices. The generation of the staff to an an	d on 11/18/21 at 9:13 a.m., moved from a room #404 in the the 200 hall on 11/16/18. 9/29/21, documented Resident non-Alzheimer's disease, acute ypoxia, and heart failure. Resident ndicating intact cognition. ndent with bed mobility, transfers 415 included the following focus do the following interventions: 13/20, documented Resident #15 goal for Resident #15 revised 5 would remain safe in her				
	Resident #15 had an elect assist bar. An intervention Resident #15 used a whee A Progress Note dated 2/9 was reported to the Nursi- made inappropriate comm	ns dated 11/23/20, directed staff tric high low bed and used an n dated7/14/21 directed staff eled walker for long distance. 9/21 at 10:43 a.m., documented it e last night, that Resident #1 ments to Resident #15. Resident				
	Resident #15's room and wanted his (Resident #1's which Resident #15 replie talked for a little while an his room. When the Socia	alked into the doorway of asked if she (Resident #15)) penis. Resident #15 replied no to ed "oh, I thought you did". They d then Resident #1 went back to I Service staff talked with Resident Resident #1 did not make her				

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Facility Administrator

Citation Numb #5492	per:				Date: December 27, 2019		
	aska Specialty Care		Survey Dates: 10/20/21-12/9/21				
-	ss/City/State/Zip						
2401 Crestviev Oskaloosa, IA	_	MW/DC					
Rule or Code Section	Natur	e of Violation	Class	Fine A	Mount	Correction date	
	she would like to move ro across the hall from him. Y immediately (to a different A Progress Note dated 10, Social Services met with R incident that had occurrent time she felt uncomfortable Resident #15 stated she w Resident #15 stated she w Resident #1 walked into h TV and asked her if she wa her private area. Staff ask she shared his penis/dick. Resident #1 stood there a #15 if his clothes were on stated she was (wasn't) su Staff asked if she felt safe Resident #15 stated she w she was shocked but now happen. She stated she go able to do so without bein knows where he is and ne would talk to Social Servic stated she felt bad it took encouraged to tell from h did. Staff thanked residen The Clinical Census printe	/26/21 at 3:33 p.m., documented lesident #15 regarding a past d. Staff asked if there was ever a ole with another resident. Vas in her other room and er room while she was watching anted it. Resident #15 pointed at ed what she meant by this and Resident #15 stated no and nd then left. Staff asked Resident and Resident #15 stated yes. She are if his privates were out or not. and Resident #15 stated she did. Vould respond better. She stated she is aware and won't let that bes to activities where he is and is ng scared. She stated she always ever sits by him. She stated she her awhile to tell but she was er daughters and she is glad she t for meeting.					

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Facility Administrator

Citation Numl #5492	per:			Date Dece	: ember 27, 2019	
Facility Name: Northern Mahaska Specialty Care Facility Address/City/State/Zip 2401 Crestview Drive Oskaloosa, IA 52577		MW/DC	Survey Dates: 10/20/21-12/9/21			
Rule or Code Section	Nature of Violation		Class	Fine Amour	t Correction date	
	4. A MDS with an ARD of	8/25/21, documented Resident				

4. A MDS with an ARD of 8/25/21, documented Resident #13's diagnoses included non-Alzheimer's disease, diabetes, and heart failure. Resident #13's BIMS score was 13 indicating intact cognition. Resident #13 required limited assist of 1 with bed mobility, transfers and walking in room.	
A Care Plan for Resident #13 included the following focuses and directed staff to do the following interventions: a. A focus area dated 1/28/21, documented Resident #13 used safety devices. The goal revised on 5/26/21, for Resident #13 was she would remain safe in her environment. Interventions dated 1/28/21, directed staff Resident # 13 had a specialty call light had an electric high low bed. An intervention dated 9/8/21 directed staff that Resident # 13 had a body alarm. b. A focus area revised on 8/30/21, documented Resident #13 was an elopement risk/wanderer related to disoriented to place, impaired safety awareness and wandering aimlessly. The goals for initiated 8/24/21 were Resident #13 would be maintained safely through the review date and she would not leave the facility unattended through the review date. Interventions dated 8/24/21 directed staff to approach Resident #13 positively in a calm, accepting manner, to provide diversional activities, and she wears a wander alert. An intervention dated 8/30/21, directed staff to distract her from wandering by offering pleasant diversions, structured	
activities, food, conversation, TV shows and books. c. A focus area dated 1/28/21, documented Resident #13	
had impaired cognitive function/dementia or impaired	

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Facility Administrator

Date

Citation Numb #5492	er:			Date: Decem	ber 27, 2019	
Facility Name: Northern Maha	ska Specialty Care		Survey Dates: 10/20/21-12/9/21			
Facility Address/City/State/Zip			10/20/21-12/3/21			
2401 Crestview Drive Oskaloosa, IA 52577		MW/DC				
Rule or Code Nature o Section		e of Violation	Class	Fine Amount	Correction date	

8				
	thought process related to dementia. The goal revised on			
	5/26/21, was Resident #13 would be able to communicate			
	basic needs on a daily basis through the review date.			
	Interventions dated 1/28/21, directed staff to communicate			
	with Resident #13, her family and caregivers regarding her			
	capabilities and needs, to use her preferred name, identify			
	themselves at each interaction, face her when speaking and			
	make eye contact, reduce any distractions, provide her			
	with necessary clues, stop and return if she is agitated, and			
	keep routine consistent and try to provide consistent			
	caregivers as much as possible in order to decrease			
	confusion. An intervention dated 3/5/21, directed staff			
	Resident #13 had a sign to help locate her room.			
	A Progress Note dated 9/6/21 at 3:00 p.m., documented it			
	was reported to the Nurse that another resident came up			
	behind this resident and touched her breasts. At the time			
	this was reported the other resident had gone back to his			
	room and this resident (Resident #13) remained in the			
	dining room visiting with other female residents.			
	A Progress Note on 9/7/21 at 10:00 a.m., the Social Service			
	Coordinator met with Resident #13 regarding the			
	possible incident that occurred over the weekend. Resident			
	#13 willingly went through the sexual consent. Resident			
	#13 stated there was no one who touched her and if there			
	was they would be on the ground. Sexual consent was filed			
	in documents.			
	The Clinical Census printed on 11/18/21 at 9:17 a.m.,			
	documented Resident #13 resided in the 100 hall.			
u	P	μ	μ	Page 19 of 117

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If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Numb #5492	per:			Date Dec	ember 27, 2019
	: aska Specialty Care ess/City/State/Zip	-	Survey 10/20/21		
2401 Crestview Drive Oskaloosa, IA 52577		MW/DC			
Rule or Code Section	Nature of Violation		Class	Fine Amou	nt Correction date
		6/16/21, documented Resident			

5. A MDS with an ARD of 6/16/21, documented Resident #14's diagnoses included diabetes, bipolar disorder and Post Traumatic Stress Disorder (PTSD). Resident #14's BIMS score was 15 indicating intact cognition. Resident #		
14 required supervision of 1 with bed mobility, extensive assist of 2 for transfers, walking in room did not occur, and was independent with locomotion on and off the unit.		
A Care Plan for Resident #14 included the following focus and directed staff to do the following interventions: a. A focus area dated 9/10/21, documented Resident #14 had a history of physical or emotional trauma. The goal revised on 9/10/21, was she would not have a trauma triggered event. Interventions revised on 11/1/21, directed staff that Resident #14 de-escalation interventions were taking deep breaths, talking to someone about her needs and reminding herself that it was better now.		
The Clinical Census printed on 11/18/21 at 9:16 a.m., documented Resident #14 resided in room #209 in the 200 hall.		
6. A MDS with an ARD of 8/11/21, documented Resident #16's diagnoses included cerebral infarction, anxiety disorder, and seizure disorder. Resident #16's BIMS score was 15 indicating intact cognition. Resident #16 required extensive assist of 1 with bed mobility, extensive assist of 2 for transfers and locomotion on and off the unit, and walking in room did not occur.		
		Page 20 of <i>t</i>

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Facility Administrator

Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Numb #5492	er:			Date: Decem	ber 27, 2019		
Facility Name: Northern Maha	ska Specialty Care			Survey Dates: 10/20/21-12/9/21			
Facility Addres	ss/City/State/Zip		10/20/21	-12/3/21			
2401 Crestviev	v Drive						
Oskaloosa, IA 52577		MW/DC					
Rule or				Fine Amount	Correction		
		e of Violation	Class	Fille Amount	date		
Section	Natur		0.033				

0	1	n	
	A Care Plan for Resident #16 included the following focus		
	and directed staff to do the following interventions:		
	a. A focus area dated 7/21/21, documented Resident #16		
	was at risk for impaired communication related to visual		
	impairment and hearing difficulty. The goal revised on		
	6/2/21, was she would be able to interact with peers,		
	family and staff. Interventions revised on 7/21/20, directed		
	staff that Resident #16 can understand simple direct		
	communication, and to speak to her in a low, clear voice to		
	increase her chance of hearing.		
	The Clinical Census printed on 11/18/21 at 9:16 a.m.,		
	documented Resident #16 resided in room #208 in the 200		
	hall.		
	7. A MDS with an ARD of 10/19/21, documented Resident		
	#17's diagnoses included cerebral infarction, diabetes		
	and non-Alzheimer's dementia. Resident #17's BIMS score		
	was 15 indicating intact cognition. Resident #17 required		
	limited assist of 1 with bed mobility, transfers and walking		
	in room.		
	A Care Plan for Resident #17 included the following focus		
	and directed staff to do the following interventions:		
	a. A focus area dated 9/24/21, documented Resident #17		
	experienced unwanted sexual advances from Resident #		
	1 on 9/18/21. The goal dated on 9/24/21, was she would be		
	free of sexual advances or unwanted interaction with		
	Resident #1. Interventions revised on 9/24/21, directed		
	staff that Resident #17 is able to say no and state when I		
	don't want to interact with other residents, and she had a		
			Page 21 of 1

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Facility Administrator

Date

Citation Number: #5492 Facility Name: Northern Mahaska Specialty Care Facility Address/City/State/Zip			Survey I 10/20/21		Date: Decemi	ber 27, 2019
2401 Crestviev Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	e of Violation	Class	Fine A	mount	Correction date
	an incident was discussed a male resident had kissed shouldn't be doing that an it". Resident #17 stated ha shirt. Resident #17 stated told him not to do that an intervened. Doctor aware to significant other regard A Progress Note dated 9/2 Resident #17 was sitting t resident (Resident #1) wa He then walked to the fro hand down her shirt. The removed from lounge and Resident #17 stated that H Assistant Director of Nurs and the doctor was notified A Progress Note dated 9/2 the Social Service worker talked with her about wha Resident #17 shared that happened since. Staff ask	18/21 at 10:00 a.m., documented with resident and she stated that d her head. She told him he nd he told her "don't worry about e then put his hand down her she put her hand over his and nd he responded ok. Staff of situation and message was out ding incident. 18/21 at 10:16 a.m., documented he 200 hall lounge when a male lked in and began talking to her. int of her wheelchair and put his male resident was immediately d taken to the nursing station. he did touch her breast. The ing (ADON) notified of incident ed of the incident. 20/21 at 10:30 a.m., documented met with Resident #17 and at occurred over the weekend. a male toucher her and it had not ed her if she felt safe and Resident int #17 stated she would just				

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If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Num #5492	ber:				Date: Decemi	oer 27, 2019
Facility Name Northern Mat	e: naska Specialty Care		Survey			
-	ess/City/State/Zip			12/0/21		
2401 Crestvie Oskaloosa, I/		MW/DC				
Rule or Code Section	Natur	e of Violation	Class	Fine Ar	mount	Correction date
	the Social Service worker asked how she was doing Resident #17 said she was concerns. The Clinical Census printe documented Resident #11 time of the incident and r 8. A MDS with an ARD of #18's diagnoses included diabetes, and anxiety. Thi which indicated moderate	21/21 at 8:30 a.m., documented spoke with Resident #17 and and if she had any concerns. s doing good and did not have any ed on 11/18/21 at 9:18 a.m., 7 resided in the 400 hall at the moved to the 300 hall on 10/4/21. 8/11/2021, documented Resident non-Alzheimer's dementia, is resident's BIMS score was 9 e cognitive impairment. Resident # with set up help for bed mobility. ndent with transfers and				
	#18's diagnoses included diabetes, and anxiety. Thi which severe moderate co required supervision with resident was independen This MDS was the most re incidents below.	is resident's BIMS score was 8 ognitive impairment. Resident #18 a set up help for bed mobility. This t with transfers and ambulation. ecent MDS completed prior to the				
	and directed staff to do the	#18 included the following focus he following interventions: h 3/4/21, documented Resident e and visiting with others.				

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If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Numb #5492	er:			Date: Decem	ber 27, 2019
Facility Name: Northern Maha	ska Specialty Care		Survey I		
Facility Addres	ss/City/State/Zip		10/20/21	-12/3/21	
2401 Crestviev Oskaloosa, IA		MW/DC			
Oskalousa, IA	52511				
Rule or		м		Fine Amount	Correction
Code	Natur	e of Violation	Class		date
Section					

	Resident #18 refused to social distance during activities.			
	The goal revised on 5/12/21, was he would voice			
	satisfaction with activity involvement. Intervention dated			
	on 3/4/21, directed staff that Resident #18 would be			
	educated on social distancing.			
	b. A focus area revised on 5/27/21, documented Resident			
	#18 had displayed socially inappropriate/disruptive			
	behavior by touching a females breast. The goal dated			
	5/27/21, was this resident would not display inappropriate			
	or disruptive behaviors. An intervention dated 5/25/21,			
	directed staff to assist this resident to another part of the			
	building if staff see him wandering into another resident's			
	room. Interventions dated 5/27/21, directed staff to			
	monitor and document resident's behavior and Social			
	Services was to evaluate and visit with Resident #18 as			
	needed.			
	A Progress Note dated 5/27/21 at 5:17 p.m., showed Social			
	Services documented that on 5/25/21. Resident #18 had			
	touched Resident #22's breast. There were no injuries and			
	Resident #22 was not bothered by the encounter. Staff			
	were told to monitor Resident #18's interactions with other			
	residents. Social services spoke with Resident #18 on the			
	day of the incident and told him not to display those			
	behaviors. Resident #18 admitted to grabbing Resident			
	#22's breast and stated he would not do it again. Resident's			
	POA was notified.			
	A Progress Note dated 5/28/21 at 10:30 a.m., Nursing			
	documented she had spoken to Resident #18 regarding not			
U	N	μ	μ	Page 24 of 11

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If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Numb #5492	er:			Date: Decem	ber 27, 2019
Facility Name: Northern Maha	ska Specialty Care		Survey I 10/20/21		
-	ss/City/State/Zip		10/20/21	-12/3/21	
2401 Crestviev Oskaloosa, IA		MW/DC			
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date

going down the hallway and visiting with residents.		
Resident was informed he needed to be cautious of visiting		
in rooms due to not everyone being so accepting of his		
presence in their bedroom. Resident stated he did not even		
go down to anyone's room anymore. Social Services was		
present during the conversation.		
A Progress Note dated 5/28/21 at 10:40 a.m., Social		
Services documented she was informed Resident #19 had		
concerns that Resident #18 and Resident #1 had been in		
her room at some point in the past. Resident #19 could not		
say for sure when but it wasn't on that day. Social Services		
asked Resident #18 to not go into Resident #19's room		
and reminded him to knock before entering anyone's room.		
He stated that he understood. A stop sign was put on		
Resident #19's door.		
A Progress Note dated 5/28/21 at 4:30 p.m., documented		
resident was witnessed wandering down 100 hall in the		
direction of Resident #19's room. The Nurse followed the		
resident back to his room to again reiterate the importance		
in not entering anyone's room that may be unwanted. He		
then shoved the Nurse out of the room, attempted to		
throw his walker at the Nurse and then slammed the door		
in the Nurse's face. The DON and the doctor were informed		
of the incident. No new orders.		
A Progress Note dated 5/28/21 at 5:21, documented the		
POA was aware of resident's behaviors today and is		
planning on contacting resident and having discussion with		

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If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Num	iber:]		Dat	
#5492		_			ember 27, 2019
Facility Name Northern Ma	e: haska Specialty Care		Survey		
Facility Addr	ess/City/State/Zip		10/20/21	-12/9/21	
2401 Crestvi Oskaloosa, I		MW/DC			
Rule or Code Section	Natur	e of Violation	Class	Fine Amou	nt Correction date
а			n	<u>n</u>	II.
	him regarding privacy and residents.	d unwanted visits to female			
	-	ed on 11/18/21 at 9:19 a.m.,			
	time of the incident and r	8 resided in the 400 hall at the noved to Room 217 in the 200 hall			
	on 8/1/21.				
		4/2/21, documented Resident non-Alzheimer's dementia,			
	_	BIMS score of 7 indicated Resident			
	required limited assist of	2 for bed mobility, extensive assist			
	of 2 for transfer and exte	nsive assist of 1 for locomotion			
		#19 included the following focus			
	a. A focus area revised or	he following interventions: 16/16/21, documented Resident			
		nce with mobility related to oal revised on 7/7/21, was she			
		<pre>v to ambulate. Interventions ted staff Resident #19 was unable</pre>			
	to put weight on her left	lower extremity and required a			
		9/9/21, documented Resident			
		ve function/dementia impaired d to dementia. The goal revised on			
	9/9/21, was she would be	e able to voice basic needs on a			
		view date. Interventions dated on communicate with Resident #19,			

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Facility Name Northern Mar	e: naska Specialty Care		Survey [10/20/21			
Facility Addre	ess/City/State/Zip		10/20/21			
2401 Crestvie Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date	
	needs. A stop sign to door request. A Progress Note dated 5/2 Resident #19's spouse wa	regarding her capabilities and way to keep others out per her 20/21 at 5:35 p.m., documente s here (at the facility) and very said another resident had gone	d			
	into Resident #19's room husband) wanted to file a staff and they said they w A Progress Note dated 5/2 resident had no further en	and kissed her on the lips. He (f complaint. Call placed to on ca ould notify the DON. 21/21 at 12:06 a.m., documente ncounters with other resident t	the II ed hat			
	and call light within reach A Progress Note dated 5/ a CNA approached Reside demeanor. Resident #19 m #18 and Resident #1 were made unwanted sexual re- responded to the report f visiting resident with Soci concerns related to unwa alternative male residents entered her room on mul such as she was too cute into her pants. Resident # using call light if the men and a stop sign was place	her room resting with eyes close 28/21 at 10:00 a.m., documenter nt #19 in regards to changed reported to the CNA that Reside e in her room that morning and marks toward her. The nurse the rom the CNA by assessing and al Services. Resident voiced nted sexual remarks from 5. Resident #19 stated they have tiple occasions and make remark and they wished they could get 19 was once again educated or ever enter her room unwanted d at residents doorway. The Nu c was scheduled down Resident	ed ent hen e rks n ly rse			

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	: aska Specialty Care ess/City/State/Zip	-	Survey 10/20/21	Dates: I-12/9/21		
2401 Crestvie Oskaloosa, IA	w Drive	MW/DC				
Rule or Code Section	Natur	e of Violation	Class	Fine Ar	mount	Correction date
	 morning but had not seen A Progress Note dated 5/2 Social Services was inform that Resident #18 and resident #19 time of the kissing incider on that day (5/20/21). 10. A MDS with an ARD of #22's diagnoses included in diabetes, and depression. indicating severe cognitive required extensive assist of 2 for trianal and directed staff to do the second and the second as a second second and second as a second second as a second second as a second second second as a second seco	said she had been on the hall all n either resident down that hall. 28/21 at 10:59 a.m., documented ned Resident #19 had concerns sident #1 had been in her room at ne couldn't say for sure when but e spoke with Resident #18 and Resident #19's room again and to g anyone's room. Resident #19 top sign was placed on Resident # d on 11/18/21 at 9:15 a.m., 9 resided in the 200 hall at the nt and was moved to the 100 hall f 9/15/21, documented Resident non-Alzheimer's dementia, Resident #22's BIMS score was 2 e impairment. Resident #22 of 1 for bed mobility and ansfers and walking in room. #22 included the following focus ne following interventions: 3/20/20, documented Resident				

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Facility Name: Northern Mah	aska Specialty Care		Survey		JI	
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2401 Crestviev Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	e of Violation	Class	Fine A	Amount	Correction date
	guard on her right wrist and by offering pleasant diver and conversation. b. A focus area revised on #22 had difficulty express goals revised on 6/16/21, her ideas or wants and wo peers, family and staff. Int directed staff to allow her could best understand sim provide a quiet environme discussing important issue clear voice to increase her A Progress Note dated 5/2 staff member was passing saw Resident #18 was gra she liked it. The staff mem yes. Staff called out Residu told Resident #22 he had the staff member how his told Resident #18 he could that. Resident #18. Reside of incident. The daughter	ed staff Resident #22 has a wander nd to distract her from wandering sions, structured activities, food 3/9/20, documented Resident ing her ideas or wants. The was she would be able to express ould be able to interact with her terventions dated on 2/26/20, plenty of time to respond, she nple, direct communication, to ent for Resident #22 when es and to speak to her in a low, r chances of hearing. 25/21 at 2:31 p.m., documented a glaundry to Resident #22 and bbing her left boob and asking if nber heard Resident #22 say ent #18's name and Resident #18 to go. Resident #18 then asked day was going. The staff member d not enter ladies room and do ized and left the room. The staff rse. The Nurse went to Resident ok. The resident smiled and said he resident's left breast. There e and Social Services went to talk int #22's daughter was notified laughed and said OK as long as injured. Informed daughter they				

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2401 Crestvie Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	e of Violation	Class	Fine A	mount	Correction date
	 #22's room. Resident #22' The Clinical Census printer documented Resident #22 time of the incident and s the survey. An undated facility floor p showed the room number throughout the survey, reopen to the residents and closed or locked doors from hallways from the nurse's In an interview on 10/20/stated the problem with t so lax about what they are said it was consensual witt they put her husband on s probably 1-1 ½ months pr they were going to put an know when he went out of with administration. In Jurwith mood swings and sea an antibiotic for a UTI (uri putting him up by the nur helping. They wanted to m facilities and she told ther ago they called her and to the sea and she told ther ago they called her and to the sea and the sea and the sea and the sea and she told ther ago they called her and to the sea and she told ther ago they called her and the sea and the s	dent #18 from entering Resident 's daughter had no concerns. d on 11/18/21 at 9:19 a.m., 2 resided in the 400 hall at the till resided there at the time of alan provided by the facility, rs of each hall. Observations vealed all four hallways were these hallways did not have om the points of entry to the station. 21 at 3:41 p.m., Resident #1's wife he facility was they have been e doing. She stated the prior DON h the incidents. She stated some medications, Depakote, ior then increased it. She was told alarm in his doorway to let them of his room. Lots of changes ne he had increased behaviors kual thoughts. He was placed on nary tract infection). They were se's station and that had been nove him to one of their sister n no. She said about 1 ½ months old her he had touched another n called her back and said he				

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	haska Specialty Care	-	Survey 10/20/21	Dates: I-12/9/21		
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Rule or Code Section	Natur	re of Violation	Fine Amount Co			Correction date
	COVID 19 and being stuck etc.	is behaviors had been related to k in his room, eating in his room,				
	facility had called him and mother ice chips. The som was in his mother's room mother and his mother w The facility was going to r any incidents before this. room was from the male across the hall from him. under control. They were stated he was kind of bef it and then they had aske	., Resident #2's son, stated the d said they went in to give his in stated the facility told him a male of and the male was touching his vas touching the male resident. monitor. The son was not aware of the asked how close his mother's resident and he was told she was the stated hopefully they got it e doing 15 minute checks. He fuddled when they told him about ed if he had any questions. He told all the facility does a good job and	f			
	#1 and Resident #2 were rooms were across the ha An observation on 10/21, Resident #2 remained in resident next to the door Resident #2's recliner was Resident # 2's roommate recliner next to the windo room sitting with another	/21 at 9:20 a.m., revealed Residen in their respective rooms. The all from each other. /21 at 11:00 a.m., revealed her room. She was the first rupon entrance in to the room. s closer to the door than her bed. appeared to be asleep in her ow. Resident #1 was in the dining r male resident. The alarm was ot sound at the door. A red light	t			

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Citation Num #5492	ber:				Date: Decemb	oer 27, 2019
Facility Name: Northern Mahaska Specialty Care Facility Address/City/State/Zip 2401 Crestview Drive Oskaloosa, IA 52577		 	Survey I - 10/20/21			
Oskaloosa, IA 52577 Rule or Code Natur		re of Violation	Class	Fine Am	nount	Correction date
Section						
	This resident's male room	walked under but did not sound. Imate was in his bed and appeared ate was the second resident from				

This resident's male roommate was in his bed and appeared to be asleep. The roommate was the second resident from the door in their room (Resident #1 was the first resident from the door in the room).	
On 10/21/21 at 11:50 a.m., the DON walked in and out of Resident #1's room. The alarm sounded at the nurse's station only and only sounded when the DON was in the doorway. The alarm sounded for 5 seconds.	
On 10/21/21 at 12:17 p.m., Resident #1 was sitting at nursing station alone. When asked how his lunch was he nodded. He would not answer any other questions. Resident had a flat affect. Shortly after this Resident #1 waved at a female resident who walked past Resident #1 on her way to the rehab room.	
On 10/21/21 at 12:29 p.m., the Medical Director (MD), when asked about Resident #1, stated he did increase the Depakote once. He stated to be honest the literature isn't good on Depakote nor was it good with female hormones. The MD stated he didn't know what the answer was. He did not think Resident #1's wife wanted the resident moved. Other facilities were hesitant to take him because of his behaviors. He stated there are a lot of dependent adults there at the facility. The facility was doing a lot of checks on Resident #1. The MD stated Resident #1 is sneaky. The MD did not know about the door alarm. He stated they had been trying to get Resident #1 moved. He stated his	
resignation date was 10/31/21 and the next Medical	

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2401 Crestviev	v Drive				
Oskaloosa, IA	52577	MW/DC			
Rule or		<u>µ</u>		Fine Amount	Correction
Code	Natur	e of Violation	Class		date
Section					

Director could try something. He stated it was a hard		
behavior to quantitate. He stated he hated to medicate		
people and felt the facility had put interventions in place.		
He did not want to be completely unrealistic to say it will be		
100% effective. The biggest thing was they needed to move		
the resident and the wife was not supportive. The MD also		
did not want to move issues to another facility. He stated		
the literature is not good and anecdotal. The MD stated he		
needed to protect other residents too and a lot of it was		
trial and error, he state he was just trying to find the best		
combination. MD was asked about the female residents		
that were on the timeline provided by the facility undated		
list of Resident #1's current interventions. He stated		
Resident #13's reliability was questionable. He believed		
that she would defend herself. The MD stated Resident #13		
had said if Resident #1 would have touched her breasts she		
would have kicked him. The MD stated that interview with		
staff they didn't really know if they did see it as pillars were		
in the way. In regards to Resident #17, he stated he		
would definitely trust Resident #17's account. In regards to		
Resident #2, the MD stated she was not completely		
reliable. He was told that she was reciprocating in that		
instance. The MD stated Resident #2 is an emotional lady.		
He stated if it was his mom he would not have liked it.		
On 10/21/21 at 1:03 p.m., Resident #2 stated she had no		
concerns with her care at the facility. When asked about		
the resident across the hall, she stated he had never		
bothered her.		
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2401 Crestviev Oskaloosa, IA		MW/DC			
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date

	On 10/21/21 at 1:22 p.m., Staff I, Licensed Practical Nurse			
	(LPN), stated she was walking down the hall the day of			
	one of the incidents to do a skilled assessment. The CNA			
	(Staff D) told her they had a situation. Staff D told Staff I			
	that Resident #2 was sitting on Resident #1's lap and he			
	was fondling Resident #2's breasts. It happened sometime			
	between 2 p.m. and 5 p.m. Staff I entered the room and at			
	that time Resident #1 was sitting in the recliner and			
	Resident #2 was walking toward the foot of her bed and			
	then Resident #2 sat down on her bed. There was probably			
	1 ½ feet between the recliner and the foot of the bed. Staff			
	I stated they got Resident #1 out of the room. She stated he			
	was angry by the look on his face. He didn't want to leave			
	the room. Staff I stated they had to repeat themselves 3			
	times to get him up from the recliner. Staff I offered			
	Resident #1 her hand. She stated he finally got up and went			
	to his room. Staff I stated Resident #1 likes girls you know.			
	Staff I said Resident #2 seemed upset that they had taken			
	Resident #1 out of the room. Staff I felt Resident #2 enjoyed			
	his company. She stated they both are nice people.			
	Staff I stated Resident #2 did not seem upset that anything			
	had transpired between them. Resident #2 did not			
	verbalize anything. Staff I told Nurse Supervisor who was at			
	the nurse's station. We had Resident #1 come up and			
	sit at the nurse's station. He did not seem real thrilled but			
	he came up to the nurse's station. He's not much of a			
	talker. Staff I left the interventions to the Nurse Manager.			
	The intervention they used immediately was to keep him			
	in line of site and put both of them on 15 minute checks.			
	She knew Resident #1 had left his room a couple of times			
	· · · · · · · · · · · · · · · · · · ·			
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Date

Citation Numb #5492	er:				Date: Decemi	ber 27, 2019
	aska Specialty Care		Survey Dates: 10/20/21-12/9/21		JI	
2401 Crestviev	-	MW/DC				
Oskaloosa, IA Rule or	52577			Fine A	Amount	Correction
Code Section	Natur	e of Violation	Class			date
	He went right back into hi why they had not heard it was loud at the time. On 10/25/21 at 3:05 p.m., stated she worked the nig where Resident #1 was or have the paper. She would stayed in his room. She st nurse's station for a short say 98 % of his time he was out a couple of times and She stated he was good w stated she saw him every needed to know where he well when we tell him to p females. On 10/25/21 at 3:10 p.m., had kissed her on the top hand down her shirt, whe advances made toward he not. He stopped. Staff we s since then. He doesn't u On 10/25/21 at 3:45 p.m., started 15 minute checks out of the papers. Staff E	n sounded. That's how they knew. is room. Staff I did not know e earlier, maybe it was because it , Staff E, Registered Nurse (RN), th of the incident. She wrote her hand because she didn't d keep her eye on him. He mostly ated Resident #1 did sit at the time. Other than that she would as in his room. She stated he came they responded to his alarm. The going back into his room. She 15 minutes. CNA's knew they e was. She stated he listens pretty blease stay away from other , Resident #17 stated Resident #1 of her head and then he put his n asked if she had had any er. She told him no. He asked why re there to intervene. No incident nderstand what he is doing. , Staff E, RN, stated they first for one day. After that they ran stated Resident #1 doesn't mean y. He just doesn't understand.				

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Citation Numb #5492	er:			Date: Decem	ber 27, 2019
Facility Name: Northern Maha	ska Specialty Care		Survey I		
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2401 Crestviev	v Drive				
Oskaloosa, IA	52577	MW/DC			
Rule or		μ		Fine Amount	Correction
Code	Natur	e of Violation	Class		date
Section					

		1
On 10/25/21 at 4:15 p.m., the Nursing Home Administrator (NHA), stated he did not feel Resident #1 was harming anyone. He stated Resident #1 was really a nice guy. Resident #1 didn't know what he is doing and the ladies the NHA had talked to have not been upset.		
On 10/25/21 at 4:20 p.m., the Director of Nursing (DON) reviewed Resident #1's 15 minute check documentation that she had provided. She concurred that 15 minute check documentation was missing on: 10/18/21 from 9:30 a.m. to 3:00 p.m. and from 4:00 p.m. to 11:35 p.m 10/19/21 from 4:00 a.m. to 10/20/21 at 3:45 p.m. 10/22/21 from 11:45 a.m. to 1:45 p.m. 10/23/21 from 6:15 a.m. to 1:45 p.m. The DON stated 15 minute checks were not sustainable. On 10/25/21 at 5:18 p.m., the DON stated they had stopped doing the 15 minute checks after the first 24 hours. The DON then had talked with the Nurse Consultant and was advised by the Nurse Consultant to still do the 15 minute checks. They then reinitiated the 15 minute checks on 10/20/21. The 15 minute checks were done for 24 hours		
only for Resident #2. An observation on 10/25/21 at 5:45 p.m., showed Resident #1 was in his room eating supper. His room had changed to a private room in the same hall closer to the nurse's station, Room 201. An observation on 10/25/21 at 6:00 p.m., Resident #1's alarm sounded when he walked out of his room. Resident		Page 36 of 11

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Oskaloosa, IA		MW/DC			
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date

#1 walked by the nurse's station then turned around and started to walk back to his room. He then turned and grabbed a female resident; hand. Resident #1 moved quickly. The female resident was sitting at a table in the dining area. She smiled. Staff immediately separated Resident #1. Staff walked back to Resident #1's room with him. The alarm sounded again when they entered his room. On 10/26/21 at 9:30 a.m., an observation was noted regarding Resident #1's door alarm could not be heard at the end of 400 hall. Shared the information with the DON. The DON stated staff would not always be able to hear the alarm. She stated the isone at the nurse's station to hear the alarm. She stated this is why they started a 1:1 that morning. She stated this is why they started a 1:1 that morning. She stated they have contacted their lawyer to see what they can do. Maybe find housing for him in an only male residents are pretty independent. When asked about the observation on 10/25/21 at 6:00 p.m., the DON stated she saw the same thing. She stated Resident #1 moved toward the female resident. The DON concurred Resident #1 moved fast. She stated staff responded immediately and were right there. On 10/26/21 at 10:20 a.m., Staff A, CNA stated she normally works on the 3-4 side (300 and 400 halls) but she was aware of the 1-2 side (100 and 200 halls) and was well aware of the issues with Resident #1. Staff A stated she was			
grabbed a female resident's hand. Resident #1 moved quickly. The female resident was sitting at a table in the dining area. She smiled. Staff immediately separated Resident #1. Staff walked back to Resident #1's room with him. The alarm sounded again when they entered his room. On 10/26/21 at 9:30 a.m., an observation was noted regarding Resident #1's door alarm could not be heard at the end of 400 hall. Shared the information with the DON. The DON stated staff would not always be able to hear the alarm. She stated at 6:00 a.m. when people start getting up there may not be someone at the nurse's station to hear the alarm. She stated this is why they started a 1:1 that morning. She stated this is why they started a 1:1 that morning. She stated they have contacted their lawyer to see what they can do. Maybe find housing for him in an only male resident home, such as a house that may have Down's Syndrome residents or something like that, somewhere that residents are pretty independent. When asked about the observation on 10/25/21 at 6:00 p.m., the DON stated she saw the same thing. She stated Resident #1 moved toward the female resident. The DON concurred Resident #1 moved fast. She stated staff responded immediately and were right there. On 10/26/21 at 10:20 a.m., Staff A, CNA stated she normally works on the 3-4 side (300 and 400 halls) but she was aware of the 1-2 side (100 and 200 halls) and was well aware of the issues with Resident #1. Staff A stated she was	#1 walked by the nurse's station then turned around and		
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Facility Administrator

Date

Citation Numb #5492	er:			Date: Decem	ber 27, 2019
Facility Name: Northern Maha	ska Specialty Care		Survey I		
Facility Addres	ss/City/State/Zip		10/20/21	-12/3/21	
2401 Crestviev Oskaloosa, IA		MW/DC			
Oskalousa, IA	52511				
Rule or		м		Fine Amount	Correction
Code	Natur	e of Violation	Class		date
Section					

not aware of recent incident but knew he had past behaviors. Staff A stated her "Spidey senses" go off when Resident #1 is outside of the room. Staff A stated Resident #1 had touched Resident #19 inappropriately. Staff A stated Resident #1 had asked Resident #15 if she wanted to see his genitalia. She stated they moved Resident #15 immediately. Staff A stated Resident #1 had an alarm that sounded at the nurse's station. She stated she knew the sound when it went off, but it sounded when other people (staff) would go in and out. Staff A stated he didn't' always respond because it could be another staff person setting off the alarm. She stated if she is with another resident and she asked him to go with her and she had him sit at the nurse's station. She stated he wasn't doing anything wrong at the time, she just knew he wasn't supposed to be around female residents. Staff A stated they had 5 Minute Meetings about Resident #1. She said new employees may or may not know. On 10/26/21 at 10:59 a.m., Staff F, CMA, stated Resident #1 was on frequent checks for contact with females. Staff F had not witnessed any incidents. We did have a little lady who told Staff F that Resident #1. had entered her room 3 or so times and it scared her. Staff F would genti					
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Facility Administrator

Date

Citation Numb #5492	er:			Date: Decem	ber 27, 2019
Facility Name: Northern Maha	ska Specialty Care		Survey I		
Facility Addres	ss/City/State/Zip		10/20/21	-12/3/21	
2401 Crestviev	v Drive				
Oskaloosa, IA	52577	MW/DC			
Rule or				Fine Amount	Correction
Code	Natur	e of Violation	Class		date
Section					

was standing in Resident #1's doorway. Staff F stated she		
did not do 15 minute checks the night of 10/19/21. She		
knew they had given the Nurse's forms. She was not		
personally approached to do 15 minute checks or fill out		
the papers. She stated they were told eyes on Resident #1		
at all times and to keep him at the nurse's station. Redirect		
him and keep him away (from female residents). Staff F		
stated you cannot hear the alarm go off if you are in		
another resident's room. They got rid of the floor mat they		
had because Resident #1 had figured out he could step over		
it. He could also shuffle the mat with his feet out of the		
way. Staff F thought that in late evening during p.m. cares		
staff might be in rooms and it would have been possible		
that no one would hear his alarm. Staff F stated one time		
Resident #2 tried to go over to his room. She picked up her		
walker and tried to put it over the mat. They thought it was		
a fall risk.		
On 10/26/21 at 11:21 a.m., when asked about what she		
witnessed on 10/17/21, Staff D, CNA, stated she was		
passing water and noticed one resident's (Resident #2)		
room door was closed. She opened the door and Resident		
#1 was sitting in Resident #2's recliner with Resident #2 on		
his lap. Resident #1 had one hand up Resident #2's shirt and		
his other hand wrapped around her. Staff D told Resident		
#1 he was not supposed to be in Resident #2's room. She		
told him c'mon, let's go and he said no. Staff D stated the		
Nurse was coming down the hall at that time and Staff D		
told her that they had a situation in here. Staff D stated the		
Nurse was able to get Resident #1 out. Resident #2 got off		
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Facility Administrator

Date

Citation Numb #5492	er:			Date Dece	mber 27, 2019
Facility Name: Northern Maha	ska Specialty Care		Survey [10/20/21		
Facility Addres	ss/City/State/Zip		10/20/21	- 1 2/3/2 1	
Oskaloosa, IA		MW/DC			
Rule or Code Section	Natur	e of Violation	Class	Fine Amoun	t Correction date

of his lap. Staff D stated Resident #2 was sitting on his lap willingly at the time. Staff D stated Resident #2 came to Staff D about 5-6 minutes later and told Staff D that she was sorry she did that and she was not that kind of a lady. Staff D stated they basically 1:1'd resident the rest of the night. Staff D did not remember the alarm sounding the night of the incident. She stated you can hear the alarm if you are at the nurse's station. She stated they were to fill out 15 minute checks on him and make sure he went into his room. On 10/26/21 at 11:38 a.m., Staff C, Certified Medication Aide (CMA), stated she sees Resident #1 walking around in lobby mostly. He was on 15 minute checks for his behavior. She knew the ad a doorbell that goes off at nurse's station. She knew the doorbell was somewhat effective in keeping him away from female residents. Staff C stated Resident #1 gets bored so that's not probably great for him sitting alone. Staff C stated during the day shift there's always someone at the nurse's station. She said that probably isn't the case on evening shift if Nurses are down the hall sthere wouldn't be anybody at the nurse's station. She said she did work nights and there was 1 Nurse on nights with at least 3 CNAs. She stated the				
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Facility Administrator

Citation Numb #5492	er:			Date: Decem	ber 27, 2019
Facility Name: Northern Mahaska Specialty Care			Survey I		
-	ss/City/State/Zip		10/20/21	- 1 2/ 3/ 2 1	
2401 Crestviev Oskaloosa, IA		MW/DC			
Rule or		u		Fine Amount	Correction
Code	Natur	e of Violation	Class		date
Section					

	behaviors with females. She stated one time he was in with			
	the lady across the hall. She identified the lady as			
	Resident #2. Resident #2 was sitting in her recliner and			
	Resident #1 was standing over her. He reached down to			
	her, grabbed her hand and put it on his privates. Staff H			
	reported it to a Nurse. Staff H did not remember who the			
	Nurse was. Staff H said it happened 3 or 4 weeks ago. Staff			
	H stated she redirected Resident #1 and he went willingly			
	back to his room. Staff H stated the Nurse told her she did			
	right thing. Staff H did not know if the Nurse charted on it			
	or what the Nurse did from there. Staff H stated she knew			
	he had a floor mat for an alarm but he knew how to step			
	over it. He knew he had a door alarm. The door alarm			
	sounded at the nurse's station. Staff H stated you can't hear			
	it if you are down the hall.			
	On 10/26/21 at 12:00 p.m., Resident #15 stated Resident			
	#1 had come in to the room she was in down the 200 hall.			
	Resident #1 showed her his penis and asked her if she			
	wanted it. She said no. Resident #1 said well, I thought you			
	would want it. Resident #15 told him no. She told a staff			
	person who no longer worked there. They moved her real			
	quick the next day. She didn't tell the aide until that night.			
	She didn't want to move. Resident #1 made her uneasy.			
	She stated he still did make her feel uneasy. Resident #15			
	then stated she did want to move to be away from him.			
	On 10/26/21 at 12:25 p.m., Staff K, CMA, stated it was			
	reported to her on 10/17/21 that Resident #1 was to be on			
	15 minute checks. She was off for 2 days and when she			
	returned they told her they started doing 15 minute checks			
Ш	n	μ	μ	Page 41 of 1 1

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Facility Administrator

Date

Citation Numb #5492	er:			Date: Decem	ber 27, 2019
Facility Name: Northern Maha	ska Specialty Care		Survey I		
Facility Addres	ss/City/State/Zip		10/20/21	-12/3/21	
2401 Crestviev Oskaloosa, IA		MW/DC			
Oskalousa, IA	52511				
Rule or		м		Fine Amount	Correction
Code	Natur	e of Violation	Class		date
Section					

				
	again because DIA was there and Nurses had to do it. Staff			
	K stated one night Resident #1's alarm went off and he			
	was in his underwear in boxer shorts. She state Resident #1			
	is always in boxer shorts at night. Resident #1 walked			
	down the hall. Staff K stated it looked like he was either			
	peeing on the floor or masturbating because his left arm			
	kept moving. Staff K stated one night a resident (Resident			
	#14) had come up to the nurse's station and reported a			
	man was standing 2 inches from her face. Resident #14 had			
	put her call light on and reported to Staff K that the only			
	reason she had her call light on was because she woke up			
	and a man was standing over her. Staff K stated she had			
	been in the 100 hall working that night with residents and			
	didn't hear the alarm sound until she was walking toward			
	the nurse's station. When she heard Resident #1's alarm			
	was sounding she went to the 200 hall and found resident			
	lying in his bed covered from neck down. She could tell he			
	was faking sleep. Staff K reported this to the Nurse but			
	did not know what the date was. Staff K stated that on			
	another night early in the morning Resident #1 was in his			
	boxers at 6:00/6:15 a.m. and Resident #13 reached out for			
	Resident #1's genitals. Staff K stated she reported it but			
	did not remember which Nurse was working or what day it			
	occurred on. Staff K stated he comes out of his room			
	often in his boxers. There is not always a Nurse or staff at			
	the nurse's station. She stated she has to be within 15 to			
	20 feet of the nurse's station to hear the alarm. Staff K			
	stated she did not think the other residents are safe. Staff K			
	stated she closes doors to rooms because she knows he			
	could be on the move. Resident #16 had asked Staff K to			
u	μ	J	μ	Page 42 of 11

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Date

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Facility Name: Northern Maha	aska Specialty Care		Survey I			
Facility Addre	ss/City/State/Zip		10/20/21	-12/5/21		
2401 Crestviev Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	e of Violation	Class Fine Amount Correction date			Correction date
	had woke up and he (Resi roommate. Staff K reporte were about the only 2 fen 200 hall that could say sou On 10/26/21 at 2:15 p.m. tried to give her a kiss. Sh and knew right where she afraid. She stated she had On 10/26/21 at 12:22 p.m switched to laundry a cou had seen inappropriate be approximately 1 ½ month 13. She stated from her an station facing the 200 hall Resident #13 on the chee turned her head because was trying to kiss her on t at it looked like he was to could not see. Resident #2 Staff G could tell she was Resident #1 is tall about 6 down. An agency Nurse d took Resident #1 to his ro about it. Resident #13 said said no. Staff G said Resid kind of irritated. Resident	, Resident #13 stated one man e stated she had a pretty good fist e could have put it. She was not not problems after that. h., Staff G, CNA stated she ple of weeks ago. She stated she ehavior between male and female s ago. Resident #1 and Resident # ngle she was by the nurse's l, she saw Resident #1 kiss k. Staff G believed Resident #13 she was uncomfortable and he he lips. The angle that Staff G was uching her shoulder but honestly 13 said "I need help" quite loudly. uncomfortable. Staff G stated i feet and Resident #13 was sitting eescalated the situation and om. Staff G talked to Resident #13 d he tried to kiss her and she ent #13 was kind of exasperated, #13 wanted to stay in the vas visiting with another resident.				

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	aska Specialty Care	-	Survey	Dates: -12/9/21	<u>II</u>	
2401 Crestvie Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	e of Violation	Class Fine Amount Co		Correction date	
	all of the aides what had h mobile and she thought th On 10/26/21 at 2:50 p.m., approximately a month pu middle of the night once a room. It kind of spooked h but couldn't get it to work bathroom door and starte stated Resident #1 will kis hallway just like a gentlen approximately two weeks He didn't come in very far get him out of her room. On 10/27/21 at 10:23 a.m on a 1:1 on that day. She clipboard. She had worked not signed the clipboard (she is up by the nurse's st alarm. She stated if staff a could hear the alarm. On 10/27/21 at 10:37 a.m resident did actually show She said she would worry other residents who may their mind. Resident #15 st	rior she had woke up in the and an older man was in her her. She turned on her call light k. She stated he opened her ed to unbutton her sweater. She as her hand when they pass in the				

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Citation Numb #5492	er:				Date: Decemb	oer 27, 2019
	aska Specialty Care ss/City/State/Zip		Survey I - 10/20/21		1	
2401 Crestviev Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	e of Violation	Class Fine Amount Correction date			Correction date
	On 10/27/21 at 12:52 p.m on the 200 hall stated whe man tried coming in her re She stated she just shut he happened again in month On 10/27/21 at 12:55 p.m are able to voice if they fee there were a couple of res named one resident then speak up for the resident stated Resident #2 had en one time Resident #2 stop Resident #1 waved Reside Resident #1 grabbed her h he kissed her on the lips. I call and couldn't get up to soon as Resident #14 got beeline to the nearest aid stated she looked after Re inappropriate happens to On 10/27/21 at 1:10 p.m., nights ago someone was i roommate's bed. She lifte was watching and they wa think that was okay. It wa	a., when asked if she felt residents elt unsafe, Resident #14 stated sidents that can't speak up. She stated that her roommate would she had named. Resident #14 acouraged Resident #1. She stated oped at Resident #1's door and ent #2 in. Resident #2 went in and hand and kissed it, then she thinks Resident #14 was on a phone o kind of distract Resident #2. As off the phone she made a e and told her. Resident #14 esident #2 to make sure nothing				

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Facility Administrator

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Num #5492	ıber:				Date: Deceml	ber 27, 2019
	haska Specialty Care	-	Survey 10/20/21			
Facility Addr 2401 Crestvi Oskaloosa, I		MW/DC				
Rule or Code Natu		e of Violation	Class	Fine A	mount	Correction date
Section						
	-	ommate. Resident #16 stated a neone came into her room 3 times oom.				
		n., Resident #13 stated she did not r touching her whether he is				
	got involved when Reside identified the husband as stated she knew somethin	, Staff A, CNA, stated a husband ent #1 had made advances. She Resident #19's husband. Staff #1 ng happened but didn't' see it #1 had made some kind of susband stopped it.				
	the only incident that the came in to his wife's room husband stated he did no with administration at tha not want the male reside where his wife was living. per his insistence. He did hall. I demanded they mo	, Resident # 19's husband stated by had was one of the residents in and kissed her. Resident #19's it file a formal complaint. He met at time and told them that he did int going down the same hall They moved his wife right away not want her living on that same ove her that same day. He stated a complaint was because the wy from that man				
	On 10/28/21, Staff B, Mai Nursing Home Administra and said they needed an	intenance Supervisor, stated the ator (NHA), had approached him alarm for Resident #1. He found re alarm through word of mouth.				

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Facility Administrator

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Citation Numb #5492	er:			Date: Decem	ber 27, 2019	
Facility Name: Northern Maha	ska Specialty Care		Survey Dates: 10/20/21-12/9/21			
Facility Addres	ss/City/State/Zip	10/20/21-12/9/21				
2401 Crestviev Oskaloosa, IA		MW/DC				
Oskalousa, IA	52511					
Rule or		м		Fine Amount	Correction	
Code	Natur	e of Violation	Class		date	
Section						

He went up town and got the alarm. They did start with an		
alarm that was a sensor mat to the floor. Staff B had		
concern regarding it being a trip hazard but Resident #1		
was pretty surefooted and his roommate at the time was in		
a wheelchair. The doormat would ring until someone would		
shut it off. Staff B stated that Resident #1 would step		
over the mat so it failed to alarm staff. Staff B said Resident		
#1 was a big guy and had a rather large stride. Staff B		
stated he was asked to get something different. He placed		
an alarm above the door on 9/20/21. Staff B stated the		
alarm sounds when someone passes underneath the alarm		
in the doorway. It does not continue to sound until		
someone turns it off. The alarm does not alert staff through		
the call light system/board. He stated if the alarm is not		
heard by the staff at the time it is set off then there is no		
other way staff would know it had sounded.		
On 11/2/21at 4:35 p.m., when asked how she would have		
felt if resident had not been confused and knew what he		
was doing, Resident #17 stated she would have felt		
horrible.		
During observation on 11/2/21 at 11:10 a.m., it was noted		
Resident #1 was rooming with Resident #18 with a CNA		
sitting outside of their doorway. Both residents were in the		
room. The CNA stated she wasn't sure when the		
residents moved into the room together but they were in		
the room together over the weekend.		
On 11/2/21 at 4:40 p.m., when asked how she would have		
felt if resident had not been confused and knew what he		
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Facility Administrator

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Citation Numb #5492	er:				Date: Decemi	ber 27, 2019
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	ss/City/State/Zip		10/20/21	-12/9/21		
2401 Crestviev Oskaloosa, IA		MW/DC				
Rule or				Fine A	mount	Correction
Code Section	Natur	e of Violation	Class			date
			1	1		
	was doing, Resident #15 s worse. She would have fe	tated that would have been It worse.				
		esident #22's daughter stated she				
	was aware of the incident were going to keep a clos	. Facility had alerted her and er eve out.				
	given the IJ template on 1	f the immediate jeopardy and 0/27/21 at 1:00 PM. The				
	immediate jeopardy was a the facility provided educ	abated on October 28, 2021 after				
	prevention and reporting	Resident #1 was placed on 1:1				
	continuous observation. A been lowered to an E afte	At exit the scope and severity had				
	implementation of the ab					
		ere also identified with F689 but				
	not included with the imn	nediate jeopardy concerns.				
		9/1/21, documented Resident				
	#6's diagnoses included n peripheral vascular diseas	on-Alzheimer's disease, se, and depression. Resident #6's				
	BIMS score was 11 indicat	ing moderately impaired				
		quired extensive assist of 2 with				
	assist of 1 for locomotion	d not occur and required limited on the unit.				
		6 included the following focus				
		o do the following interventions: 28/21, documented Resident #6				

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was at risk for falls related to diagnoses of hypertension,

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Facility Name: Northern Maha	ska Specialty Care		Survey Dates: 10/20/21-12/9/21		
-	ss/City/State/Zip		10/20/21	- 1 2/ 3/ 2 1	
2401 Crestviev Oskaloosa, IA		MW/DC			
Rule or		u		Fine Amount	Correction
Code	Natur	e of Violation	Class		date
Section					

 peripheral vascular disease, depression, chronic pain, general weakness and possible medication side effects. The goal for Resident #6 revised 6/2/21, was she would not experience any injuries related to falls that require sutures or hospitalization. Interventions dated 8/20/21 directed staff that resident was to have physical and occupational therapies evaluate and treat. An intervention dated 6/8/15 directed staff that Resident #6 used a wheel chair for mobility. b. A focus area dated 6/8/15, documented Resident #6 was at risk for a decline in ADL function related to diagnoses of general weakness, chronic pain, depression, and possible medication side effects. The goal for Resident #6 was she would be able to participate in all of her ADLs. An intervention revised on 7/10/19 directed staff that Resident #6 remained on 7/10/19 directed staff that Resident #6 remained on 7/10/19 directed staff that Resident #6 remained on fall follow up from being lowered to the floor on 8/10/21. It documented her emained with no injuries and no new complaints of pain or acute distress. Resident #6 was lying in bed, respirations were non-labored and even, and the call light was within reach. The vital signs were documented as temperature 97.5 and taken on 8/10/21 at 11:59 p.m., pulse 68 taken on 8/10/21 at 5:10 p.m., oxygen saturation of 93 % on 8/10/21 at 5:10 p.m. and pain was rated at 0 on 8/10/21 at 8:26 p.m. 	n			
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rated at 0 on 8/10/21 at 8:26 p.m.				
			J	Page 49 of 11 '

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Facility Administrator

Citation Numb #5492	per:				Date: Deceml	oer 27, 2019
	aska Specialty Care ss/City/State/Zip		Survey 10/20/21		<u>J</u>	
2401 Crestviev Oskaloosa, IA	w Drive	MW/DC				
Rule or Code Section	Natur	e of Violation				Correction date
	itself, what happened or v place. The previous entry 8/5/21 at 8:52 a.m. On 10/27/21 Staff L, Temp staff do not do transfers a On 11/1/16 at 3:03 p.m., I mother told him her whee to the facility and they sai mother did not get it arou arm. She's not real small o a loop. He stated he knew staff. He talked with admi there) and she told him the themselves. The son state lift with one person. He st short-handed every day. H especially on the weeken the facility to work at othe his mother had bruises on down as easy as they coul notified of his mother's fa Nurse Practitioner she tol fall either. The son stated mother to just get up and said that the Nurse was on	the Progress Notes of the fall what interventions were put into to this entry was documented on porary Nurse Aide (TNA), stated appropriately. Resident #6's son stated his elchair broke at first. The son went id whoever put the belt on his und her back and underneath her of a lady and it kind of took her for of they were supposed to use 2 nistration staff (who is no longer hat staff sometimes do lifts by ed they are not supposed to do a cated his mother said they are he knew they were short-handed ds. He said some staff had left er nursing homes. The son stated her legs. He thought they let her id. The son stated he was not II and when he talked with the d him she was not aware of the that one day a staff Nurse told his walk over to the chair. The son ne of them that dropped his le stated his mother does not				

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Facility Administrator

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Numb	per:				Date: Decemi	ber 27, 2019
Facility Addre	aska Specialty Care ss/City/State/Zip		Survey - 10/20/21			
2401 Crestviev Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	e of Violation	Class	Fine A	mount	Correction date
	broke and she dropped to not get hurt. When asked when a fall happens, Resid parents, mom and dad, sh 11/3/21 at 2:50 p.m., Staf hearing about Resident #6 lowered to the floor. Staff worked that night. When was assigned to the 100 h she stated she did not ren and see if there was anyth 11/3/21 at 3:10 p.m., Staf Resident #6 was not hurt the strap unhooked. She k transferring Resident #6 v all she could remember. On 11/4/21 at 2:43 p.m., 9 working the evening that floor. She stated they had assist of 1. Staff M stated Resident #6 into the bath and one of the straps cam Resident #6 went to put h lift she bumped the strap on that side causing the st	f N, RN, stated she remembered 5's transfer where she was f N did not remember if she told she was on the schedule and hall (the hall Resident #6 lived on, nember. She will think about it				

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Facility Administrator

Citation Numb #5492	er:			Date: Decem	ber 27, 2019	
Facility Name: Northern Maha	aska Specialty Care		Survey Dates: 10/20/21-12/9/21			
Facility Addres	ss/City/State/Zip	10/20/21-12/9/21				
2401 Crestviev	v Drive					
Oskaloosa, IA	52577	MW/DC				
Rule or				Fine Amount	Correction	
Code	Natur	e of Violation	Class		date	
Section						

#6 did not drop, she can kind of held on to support part of		
her weight. Staff M put her knee under her bottom and		
unhooked Resident #6 from the lift then lowered Resident		
#6 to the floor. Staff M stated Resident #6 was scared.		
Staff M told Resident #6 that everything was going to be		
alright and told Resident #6 they would get her up and back		
into her wheelchair, and would make sure Resident #6 was		
okay. Staff M stated Resident #6 said okay and was still		
scared and asked Staff M to hurry. Staff M paged Staff N,		
RN, with her walkie talkie. The nurse, Staff N, did an		
assessment and they had to get another CNA to come and		
help get Resident #6 up off of the floor. They put a gait		
belt on Resident #6 and another CNA, Staff O, with Staff M		
lifted Resident #6 up while Staff N helped with the		
wheelchair. Staff M stated Resident #6 was fine but had		
said her bottom was sore. Staff M stated the nurse had		
looked at Resident #6's bottom. She thought this occurred		
before supper but could not quite remember. Staff M said		
they had gotten certified to do 1 man lifts with the EZ		
stand. Staff M said Hoyer lifts remain a 2 person assist. She		
said the old DON was the one who did the certification.		
Staff M believed that the EZ Stand was put into the		
maintenance log. She stated there were 4 or 5 EZ stands in		
the facility. She stated she thought they used another		
stand to get Resident #6 off of the floor and placed the		
stand that she had used when she needed to lower this		
resident to the ground into the soiled utility room. Staff M		
stated the facility still does 1 person EZ stand lifts. Staff		
M stated she does not lift Resident #6 alone since the		
incident, she always grabs another person. Staff M stated		
they had filled out a paper for certification. The training		
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Facility Administrator

Date

		3				
Citation Num #5492	ber:				Date: Decemi	ber 27, 2019
#0432						
Facility Name			Survey I	Dates:		
	naska Specialty Care		10/20/21	-12/9/21		
Facility Addro	ess/City/State/Zip					
2401 Crestvie	-	MW/DC				
Oskaloosa, IA	A 52577					
Rule or				Fine A	Amount	Correction
Code	Natur	e of Violation	Class			date
Section						
	lasted long enough to kno	ow how to properly use the stands				
		ss than 30 minutes. She knew that				
		ned. She knew agency staff still				
		stated the way she understood it				
		les can assist with lifts but cannot	t			
	do the lifts by themselves					
	On 11/4/21 at 3:45 p.m.,	Staff O, CNA, stated he was				
		nt #6 was transferred and lowered				
	to the floor. Staff O stated	d Staff M was transferring				
		tand. He stated that you can do				
		h 1 assist now. He stated the sling				
		and Staff M was holding Resident				
		was behind Resident #6 holding de of the sling was undone. The				
		n the room and they both got				
	-	e. They assisted her helping to				
		neelchair. Staff O stated they then				
	used the same lift and too	ok her to the bathroom. That lift				
		sm in place to stop the sling from				
	_	ey attached both sling handles				
		ra protection. Staff O stated there				
		ack, to adapt for bigger and cumferences. Staff O stated he				
		1 man EZ stand transfer. He				
		facility directed 1 man EZ Stand				
		acility had given 5 Minute				
	Meeting on switching to B	Z stand to 1 man assisted				
	0	nute Meeting there was a 5 minute				
	-	through the check sheet. Then				
	when you have an EZ star	nd you get someone to watch you				

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Facility Administrator

Date

Citation Num #5492	ber:				Date: Decemb	ber 27, 2019
Facility Name: Northern Mahaska Specialty Care Facility Address/City/State/Zip			Survey - 10/20/21	Dates: -12/9/21		
2401 Crestvie Oskaloosa, I/		MW/DC				
Rule or Code Section	Natur	re of Violation	Class	Fine Am	ount	Correction date
	 300 hall that uses an EZ S stated you would know w the shift to shift report. H during report due to falls On 11/4/21 at 4:00 p.m., through with Staff O, rew in the facility. 3 of them o stand had 1 safety pin an safety pin. 12. A MDS with an ARD o #3's diagnoses included C disease, and paraplegia. F indicating intact cognition extensive assist of 2 with occur and required set up unit. A Care Plan for Resident # 12/10/18. The goals for R were to increase independing part of his ADLs. An int 8/31/21, directed staff the Stand for transfers to the A Progress Note dated 11 Resident #3 was assessed noted. Resident had state 	observations during a walk ealed 4 EZ stands were being used did not have safety pins. The 4th d was missing the other (2nd) f 9/1/21, documented Resident CVA, peripheral vascular Resident #3's BIMS score was 15				

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Facility Administrator

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Numb #5492	er:			Date: Decem	ber 27, 2019
Facility Name: Northern Mahaska Specialty Care			Survey Dates: 10/20/21-12/9/21		
Facility Addres	ss/City/State/Zip		- 10/20/21-12/9/21		
2401 Crestview Drive Oskaloosa, IA 52577		MW/DC			
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date

sling. It documented that this resident stated th	
fell. The Nurse documented staff and the Nurse	got a
larger sling that was a seat sling for the EZ Stand	l. Resident
#3 refused to have the day CNA's assist him to t	he
restroom. Resident turned on his call light and r	efused to
shut it off due to his feeling that CNA's would no	ot have the
2nd shift CNAs come and help him. Resident wa	s assisted to
the restroom by 2nd shift CNAs.	
A Progress Note dated 11/6/21 at 6:36 a.m., do	cumented
the reason for evaluation was a follow up to a w	
fall. It documented resident had rested quietly a	
with no complaints voiced.	
A Weight Summary printed on 11/30/21, docum	nented
Resident #3's height was 73.0 inches and his we	ight was
301.4 pounds on 9/14/21.	
In an email sent from Resident #3 and dated 11,	/5/21 at
5:09 p.m., Resident #3 wrote that on that day the	ne CNA's
had went to put him on to the toilet. They brou	
Stand in with the small lifting strap. Resident #3	
he told the staff he needed the large or extra la	
and they ignored him. He wrote the staff did no	
straps correctly and one side came loose, the le	
until they could lower him to the floor. He was l	-
did not get hurt. They only fastened one strap in	
two. He tried to tell them that he needed the la	-
and to fasten both straps. They tried to tell the	
the CNA on the next shift and they had no idea	what

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Facility Administrator

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Number: #5492					Date: Deceml	ber 27, 2019
	aska Specialty Care ss/City/State/Zip		Survey 10/20/21			
2401 Crestviev Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	e of Violation	Class	Fine An	nount	Correction date
	anyone else and do whate On 11/8/21 at 2:30 p.m., I wrong belt on him. They b people. He stated he had on him. The CNA stated sh sling. Resident #3 stated t ordered him a purple sling was on top of the curly cu slid right out. He stated it that came off. He stated h was gone at that time. He from management didn't they used the hoyer lift to Nurse came in and told hi On 11/8/21 on 3:19 p.m., used an EZ Stand. She and Resident #3 up to the EZ St the sudden the right sling 2:00 p.m Staff P had no i stated the clip that came a We were both stunned or Staff P stated on the EZ St the left clip was not there mentioned it. We found o across his rib cage at mid were going toward the ba	Resident #3 stated they used the prought a belt in used for tiny told them all not to use that slim he could not find the purple he week prior the facility had g. Resident #3 stated the strap he and not inside of it so the strat was the strap on the right side he had a little ache and pain but stated he was surprised someo come to talk with him. He said get him off of the ground. A m she did a report on it.	g p it ne of e e ed ng			

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Facility Administrator

Date

Citation Numb #5492	er:			Date: Decem	ber 27, 2019	
Facility Name: Northern Maha	ska Specialty Care		Survey Dates: 10/20/21-12/9/21			
Facility Addres	ss/City/State/Zip		10/20/21-12/9/21			
2401 Crestview Drive Oskaloosa, IA 52577		MW/DC				
Oskalousa, IA	52511					
Rule or		м		Fine Amount	Correction	
Code Nature		e of Violation	Class		date	
Section						

	Q kept a hold of the sling and was able to guide him down.			
	She stated Staff Q had her hand kind of by the door and so			
	he just kind of glided down. She stated Staff Q was backing			
	in to the bathroom and was able to block the resident			
	from hitting the door frame. Staff P reported this resident			
	was not injured. She was not sure who the Nurse was. She			
	stated the Nurse was outside of his door doing charting and			
	so she came in and assessed the resident. Staff P stated			
	at that point they used a hoyer and the hoyer sling to			
	transfer him back to his chair. Resident #3 stated he			
	wanted to wait a little bit and he would just sit in his			
	wheelchair. Staff P stated that this had never happened to			
	her before. She stated they had been taught to use both			
	hooks on straps, to use second strap as a safety back up.			
	Staff P stated she had done about 3 weeks of orientation.			
	She stated she was trained to use 2 staff for both the EZ			
	Stand and for Hoyer lift transfers.			
	On 11/8/21 at 1:35 p.m., the Maintenance Supervisor,			
	stated they do monthly maintenance on their lifts. He			
	stated he had received a list of models the company was			
	going to get rid of as the model lines were discontinued 20			
	years ago. He stated that 3 of the EZ Stands that they have			
	are on this list. He stated they have some parts but if the			
	actuator went out they would not be able to fix the 3 lifts.			
	When looking at the 4 lifts in the halls he noted one of the			
	safety clips on one of the EZ Stand lift arms missing. The			
	other 3 lifts were older models and did not have safety			
	clips. He stated the missing clip was not reported to him,			
	otherwise he would have replaced the clip. He was going to			
	check his books to see if it had been reported.			
u	P	r.	*	Page 57 of 11

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Facility Administrator

Date

Citation Numb #5492	er:			Date: Decem	ber 27, 2019	
Facility Name: Northern Maha	ska Specialty Care		Survey Dates: 10/20/21-12/9/21			
Facility Addres	ss/City/State/Zip		- 10/20/21-12/9/21			
2401 Crestviev		MW/DC	-			
Oskaloosa, IA	52577					
Rule or		μ		Fine Amount	Correction	
		e of Violation	Class		date	
Section						

	On 11/8/21 at 4:00 p.m., the DON stated prior to her			
	coming to this facility, the corporation had put an email out			
	that they were going to 1 person stand lift transfers. The			
	DON stated she could find nothing in the education			
	regarding 1 person transfers. The DON stated CNAs could			
	do 1 person transfers as long as they had been trained.			
	She stated staff should be educated but the DON could only			
	find 6 staff that had been trained. The NHA stated when			
	the Maintenance Supervisor did his monthly checks he			
	would find if the clip was missing on a lift. The DON stated			
	if the older lifts did not have a clip the company should			
	have had contacted the facility to add clips if needed.			
	On 11/9/21 at 1:45 p.m., Staff R, LPN stated she was			
	actually working outside of Resident #3's door doing her			
	charting at the time this resident was lowered to the floor.			
	Staff R stated this resident had asked to go to the			
	bathroom. The 2 aides went in and then came out and said			
	Resident #3 had just fell off the EZ stand. Staff R stated			
	since it was witnessed, she asked Resident #3 what			
	happened. He said the sling just slipped off. The aide said			
	she didn't know how it came off. They both said that when			
	they started raising him it caused pressure and it kind of			
	popped off the right side. Staff R got his vital signs. They			
	then got him up with a hoyer lift. Resident #3 agreed			
	that was the safest. They put him in his wheelchair, offered			
	to take him to the restroom. Resident #3 told Staff R that			
	he had told those girls (Staff P and Staff Q) the sling was too			
	small and to go get a different one but they didn't. Staff			
	R told the resident they would get a different sling. Staff R			
	stated that one of the aides went and got a seat sling and			
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t	hey tried to hook him up in it. Resident #3 was getting			
f	frustrated and told them it wasn't going to work. Staff R			
S	stated Resident #3 told the aides to take off the sling and to			
Ę	get out of there. The sling was not hooked up to the lift.			
ר	The aides helped him get the sling off. The resident then			
S	said he was just going to have 2nd shift take him to the			
k	bathroom. Staff R stated a little later Resident #3 turned on			
	nis call light and the staff answered it. He said he			
١	wanted to wait for 2nd shift and to leave the light on.			
F	Resident #3 came and talked with Staff R about 3:20 p.m.			
ŀ	He stated he didn't want to be a jerk but that should not			
	have happened. He said he knew they didn't mean to do it.			
5	Staff R said the safety clip was on the lift. She stated she did			
r	not run the lifts enough. One of the aides said she didn't			
ŀ	know how it happened because the clip was in place. She			
١	was just as dumbfounded as Staff R. Both of the aides			
S	said it was correctly hooked. Staff R stated she asked			
F	Resident #3 right off the bat if he was hurt. He stated the			
(only thing that was hurt was his bottom from sitting on the			
f	floor waiting for everyone to get him. Staff R told the DON			
١	what had happened. She did not do an intervention at that			
	time. She did not know how the facility does that as some			
	facilities only the MDS nurses add interventions. Staff R			
	stated around that around 3:30 when Resident #3 came to			
t	alk to her, he stated the transfer went fine. He did go to			
	the bathroom. Staff R stated the last time she had worked			
ā	at this facility would have been in May and she didn't work			
	again until 11/1/21.			
	· · · · · / /·			
	On 11/9/21 at 2:07 p.m., Staff Q stated Resident #3 wanted			
	to go to the toilet. She stated they had hooked him up.			
	······································	μ	JI	Page 59 of 117

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	Staff Q stated one side of the EZ Stand had the metal piece			
	flap, security flap. They placed the strap inside of the			
	hook and then closed the flap on the outside of the strap,			
	so the strap couldn't slide out. Staff Q stated that was the			
	part that blew their minds. She could not comprehend how			
	the heck that happened. They thought maybe the piece			
	had broken. Staff Q was standing behind Resident #3			
	holding the handle on the back of the sling. She stated that			
	they got this resident standing up and we were in the			
	doorway of the bathroom when he started to go down. It			
	sounded like the strap broke, it made a ripping sound. Staff			
	Q stated they looked at the strap and it had not ripped,			
	the sides were intact. Staff Q stated this resident said he			
	wasn't hurt. Staff Q stated they used a hoyer to get him up			
	off of the ground. This resident wanted to wait for 2nd shift			
	to transfer out of his wheelchair because he didn't trust			
	them anymore. Staff Q worked the rest of the weekend			
	(the incident happened on a Friday 11/5/21) and there			
	were no further instances. She believed they had sent the			
	sling down to be looked at by maintenance. They used the			
	same lift with a different sling for the remainder of the			
	weekend. Staff Q stated that on dayshift this resident's			
	routine is that he gets up and gets dressed then turns on his			
	call light to be transferred. The only other time they use the			
	lift/transfer was when he wanted to use the bathroom.			
	On 11/9/21 at 2:25 p.m., the Maintenance Supervisor			
	stated they replaced the clips on EZ Stands with rubber			
	clips, which was okayed through EZ company. He stated			
	that he bought rubber clips for the other stands but they			
	will have to be attached with super glue. He stated that no			
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		1	1 1
	one had contacted his department regarding missing clips.		
	He stated that no sling has been turned into him since the		
	previous Friday (11/5/21). He added he does not do		
	anything with the slings unless a buckle gets broken.		
	A Lift-Mechanical: Sit to Stand procedure date 1/15,		
	documented that equipment included 2 staff members. The		
	guidelines included the number of staff members needed		
	for transfer using the Sit to Stand would be included in the		
	resident's care plan.		
	An EZ Way Smart Stand Operator's Instructions manual		
	dated 7/30/18, documented the EZ way harnesses (slings)		
	are designed to be applied or removed with a minimum		
	amount of handling of the patient. Patients vary in size,		
	shape and weight, these conditions must be taken into		
	consideration when deciding which harness and accessories		
	are suitable for each patient's needs. The manual directed		
	to attach the harness to the hooks at the end of the arm		
	using the loops at the end of the harness S with the lift arm		
	in the lowest position. The shortest loops when possible are		
	to be used to ensure patient safety and comfort. The same		
	colored loops are to be used on both sides. Verification that		
	the loops are properly hooked inside the pigtail at the end		
	of the arms and the safety catch was in place and blocking		
	the strap from exiting through the pigtail was to be done. A		
	Harness Size chart directed that a small harness was to be		
	used for patients that weighted 70-100 pounds. This size		
	chart directed that an extra large sling was to be used for		
	patients 280-450 pounds and the large sling was to be used		
	for patients 190-320 pounds.		
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If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

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	FACILITY RESPONSE:			
58.43	481—58.43(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury. Each resident shall be free from chemical and physical restraints except as follows: when authorized in writing by a physician for a specified period of time; when necessary in an emergency to protect the resident from injury to the resident or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician; and in the case of an intellectually disabled individual when ordered in writing by a physician normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II)	II	\$500.00 (Held in suspension)	UPON RECEIPT

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	_	be free from abuse, and			

residents had the right to be free from abuse, and exploitation for 6 of 8 residents reviewed, (Resident #2, #13, #15, #17, #19 and #22). The facility must not allow verbal, mental, physical or sexual abuse which resulted in an immediate jeopardy to residents' health and safety. The facility reported a census of 77 residents, 53 of the 77 residents were female.		
Findings include:		
1. A Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/4/21, documented Resident #1's diagnoses included non-Alzheimer's dementia, cerebral infarction, and renal insufficiency. The resident's Brief Interview for Mental Status (BIMS) score was 7 which indicated severe cognitive impairment. Resident #1 was independent with bed mobility, transfers, and walking in room.		
A Care Plan for Resident #1 included the following focus areas and directed staff to do the following interventions: a. A focus area with a revision date of 8/8/21, documented Resident #1 had an emotional and physical relationship with Peer Resident #8 and was comfortable with physical affection of hugging and kissing and was comfortable with saying no or being told no and stopping if any further progression makes them uncomfortable. The goals revised on 8/4/21, documented Resident #1 would be free from physical/emotional contact with Resident #9 that would make Resident #1 uncomfortable. Resident #1 would be able to tell Resident #9 no if he was		

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uncomfortable with physical contact. Interventions with a	
date initiated on 7/5/19, directed staff to conduct an	
additional assessment of understanding of consent if	
changes in mental status or behavioral difficulties are	
demonstrated and to monitor Resident #1's ability to	
accurately identify and express type of emotional and	
physical consensual contact ongoing. An intervention	
revised on 8/18//21, directed staff to provide privacy for	
Resident #1 and Resident #8 as needed and to direct them	
to Resident #8's room as to not disrupt Resident #1's	
roommate.	
b. A focus area revised on 3/4/21, documented Resident #1	
enjoyed visiting with peers and Resident #1 refused to	
social distance during activities. His goal was documented	
he would engage in self-directed leisure pursuits,	
watching TV and reading the newspaper. An intervention	
dated 3/4/21, directed staff to provide education to	
resident regarding social distancing. An intervention dated	
11/12/18, directed staff to respect Resident #1's decisions	
for self-directed leisure pursuits. An intervention revised on	
7/18/19, directed staff to support his self-determination	
in activities of choice which included that he sometimes	
liked to walk around the facility.	
c. A focus area revised on 11/20/18, documented Resident	
#1 was at risk for decline in ADL (Activities of Daily	
Living) function related to diagnoses which included	
dementia, aphasia (a comprehension and communication	
(reading, speaking, or writing disorder resulting from	
damage or injury to the specific area in the brain), and	
possible medication side effects. The goal revised on	
10/27/21, was for Resident #1 to participate in part of his	
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	ADLs. Interventions dated 11/20/18, directed staff to give		
	Resident #1 verbal cues to help prompt him and that		
	Resident #1 was independent with transfers and		
	ambulation in the facility without the need of assistive		
	devices.		
	d. A focus area revised on 9/20/21 documented Resident		
	#1 had a history of acting out with physical and verbal		
	comments and actions of a sexual nature towards residents		
	and staff when he had an untreated infection. It		
	documented that as a reminder when he was in the		
	community he had been a very affectionate person which		
	included hand holding, arm pats, and kissing on the top of		
	the head. The resident's goal was to have fewer episodes of		
	inappropriate comments toward female staff. Interventions		
	dated as initiated on 10/18/21 directed staff that: resident		
	was started on celexa on 5/28/21 to help control sexual		
	urges, resident was started on Depakote on 9/16/21 to help		
	reduce sexual urges. It directed staff that resident's		
	depakote was increased on 9/18/21 to help with sexual		
	urges. An intervention initiated on 9/20/21 directed staff		
	that on 9/18/21 this resident would sit with staff at the		
	nurses station for all meals. A resolved intervention dated		
	9/18/21 had directed staff that this resident had a sensor		
	pad in his doorway to alert staff when he was out in the		
	public area. An intervention revised on 10/18/21, directed		
	staff the sensor pad had been removed and a doorway		
	sensor had been added on 10/4/21. An intervention revised		
	on 11/25/19 directed staff to assist resident to develop		
	more appropriate methods of coping and interacting, to		
	provide him with one on one education on appropriate vs		
	inappropriate comments towards staff. This intervention		
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gave an example to staff of you look nice today versus you		
look sexy today. This intervention directed staff to		
encourage him to express his feelings appropriately. An		
intervention dated 8/4/21, showed the resident sees		
Meditellie as needed to assist with his behaviors. An		
intervention dated 11/25/19, directed staff to remove the		
resident from public area when behavior is disruptive and		
unacceptable. An intervention dated 7/5/19, directed staff		
to notify PCP (primary care provider) for an infection		
workup if this resident displayed increasing sexual based		
actions towards staff.		
e. A focus area revised on 7/1/19, documented Resident #1		
had impaired cognitive function/dementia or impaired		
thought processed related to diagnosis of dementia and		
history of CVA (cerebrovascular accident). The resident's		
goals revised on 8/4/21, were to remain oriented to person		
and town through the review date and to be able to		
communicate basic needs on a daily basis through review		
date. An intervention revised on 11/14/18, directed staff to		
use his preferred name, identify themselves at each		
interaction, face resident when speaking and make eye		
contact, reduce distractions, and that resident understood		
consistent, simple and directive sentences. Staff were to		
provide him with necessary cues and to stop and return if		
this resident was agitated. An intervention dated 11/8/18,		
directed staff to provide cues, re-orient and supervise as		
needed.		
f. A focus area revised on 11/13/18, documented the		
resident had difficulty recalling recent events related to		
history of CVA and diagnosis of dementia. This resident's		
goal revised on 8/4/21, was that Resident #1 would be		
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able to find his room. Interventions dated 11/6/18, directed		
staff to remind this resident what their name was when		
they cared for him and to validate his thoughts and feelings		
when he got confused or anxious.		
g. A focus area revised on 11/13/18 documented the		
resident was at risk of unsafe wandering related to history		
of elopement. This resident's goal was revised on 8/4/21		
and was that his safety would be maintained through the		
review date. Interventions dated 11/6/18, directed staff		
that a monitoring device was placed on him that sounded		
alarms when he left the building and to identify patterns of		
wandering, if the wandering was purposeful, aimless or		
escapist, if he was looking for something, did he need more		
exercise and to intervene as appropriate. An intervention		
revised on 11/25/19 directed staff that he had a		
wanderguard.		
An undated list of Resident #1's current interventions was		
provided by the facility. The interventions were listed as		
follows:		
7/1/19 Emotional/Physical relationship with Resident #8		
was care planned and consents were obtained.		
7/1/19 Emotional/physical relationship with Resident #9		
was care planned and consents were obtained.		
5/28/21 Resident started Celexa.		
9/6/21 Touched Resident #13's breast. Stop sign was placed		
on Resident #13's door to prevent other resident from		
entering room. The residents were separated.		
9/16/21 Resident started on Depakote 250 mg BID (twice a		
day).		

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		d Resident #17. The behavior was			

5/10/21 Resident touched Resident #17. The behavior was			
not reciprocated. Resident was to stay at nurses station			
during waking hours. Alarm in doorway and Depakote was			
increased to 500 mg BID.			
10/4/21 A sensory pad was added to the doorway, door			
alarm removed.			l
10/17/21 Resident #1 was sitting in Resident #2's room			
with her in his lap. Residents were separated and 15 minute			
checks were initiated.			
Resident #1's Progress Notes documented the following:			
* On 2/9/21 at 1:16 p.m., Resident #1 was reported making			
inappropriate statements to the resident across the hall			
(Resident #15). Resident #15 requested room change per			
her preference and was moved to the 300 hall.			
* On 5/20/21 at 5:30 p.m., a visitor approached staff and			
stated Resident #1 had gone into his wife's (Resident #19)			
room and kissed her on her lips. The visitor stated he			
wanted to file a complaint.			
* On 5/21/21 at 3:01 a.m., the resident had been in his			
room resting in bed with eyes closed . He did not make any			
attempts to go into other residents rooms or make physical			
contact with other residents.			
* On 5/27/21 at 7:05 p.m., a clean catch UA (urinalysis) was			
collected and dropped off, the results were pending.			
* On 5/28/21 at 11:00 a.m., the Social Services staff			
documented she was informed Resident #19 had concerns			
that Resident #1 and Resident #18 had been in her room at			
some point in the past but not on that day. The SS staff			
documented she spoke to Resident #18 and told him to			
knock before entering anyone's room and to not go into			1
	•	P	

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	 #19's door. * On 5/28/21 at 1:42 p.m. Celexa after a long discuss Services about resident's building and was okay wit * On 5/28/21 at 1:45 p.m. the doctor and was clean. * On 6/3/21 at 3:58 p.m., phoned in order to update wanted a UA due to chang and the results were nega * On 7/19/21 at 11:08 a.m. psychiatric visit with PhD recent incident he had wir and that is important for 1 appropriate at all times. * On 7/20/21 at 4:44 p.m. that Resident #1 attempte away from the resident an The CNA was instructed to the room with her. 	 a, the UA was back from review by No new orders were obtained. b POA (Power of Attorney) was e on Celexa . The family ge in behavior. UA was obtained itive. c, Resident #1 had a tele therapist. They discussed the th a CNA (Certified Nurse Aide) him to remain sexually c, A CNA reported to the Nurse ed to kiss her. The CNA stepped and did not welcome his advances. c) take another staff person into it was reported to the Nurse that 				

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room.

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(Resident #13) and touched her breasts. When this was reported Resident #1 had already ambulated back to his

* On 9/7/21 at 10:35 a.m., the Social Service Coordinator met with Resident #1 about the incident that had occurred over the weekend. The Social Service Coordinator did the sexual consent willing and stated he did not recall

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touching a female's breast.		
* On 9/10/21 at 4:04 a.m., monitoring for sexual behaviors		
and there were no behaviors that shift. Resident was		
about the facility per his usual without incidents.		
* On 9/16/21 at 3:47 p.m., new order for Depakote 250 mg		
BID mood stabilizer.		
* On 9/18/21 at 9:59 a.m., a female resident (Resident #17)		
was sitting in lounge when Resident #1 walked up to her		
and then began talking to her. He then went to the front of		
her wheelchair and then put his hand down her shirt and		
touched her breast. Resident immediately removed from		
the lounge and taken to the nurses station.		
* On 9/18/21 at 10:09 a.m., Doctor notified of incident.		
Obtained an order to increase the Depakote to 500 mg BID.		
The Nurse discussed with Administrator and a 5 minute		
meeting out to staff for resident to stay at nurses station		
while awake and alarm in doorway at night time. Spouse		
was called and notified of new orders, incident and alarm.		
* On 9/19/21 at 3:12 a.m., Resident #1 remained on		
increased Depakote. Resident had no memory of incident		
with female resident. He was able to leave his room		
undetected due to being able to step over alarm pad in		
doorway.		
* On 9/20/21 at 2:17 a.m., Resident stepped on pad in		
doorway triggering the alarm at that time. The writer noted		
resident standing by his door only wearing underwear.		
When resident was approached it was noted he had the		
alarm in his hand attempting to turn it off. Writer		
requested the alarm, resident handed it over and the writer		
reset the alarm.		

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* On 9/20/21 at 9:31 a.m., Resident monitored for new		
order to increase Depakote. Resident to be at nurses		
station when awake and kept away from female residents,		
alarm on in doorway at night. No behaviors at that time.		
Resident was eating at nurses station.		
* On 9/20/21 at 11:27 a.m., the Social Service Coordinator		
met with Resident #1 and asked about him touching		
another woman. Resident #1 stated he had only touched		
his wife. Resident #1 was asked if he ever touched a		
woman there (at the facility) on her breast and he stated		
no.		
* On 10/3/21 at 3:55 p.m., the Nurse notified the Nurse		
Manager regarding alarm in the resident's doorway. The		
Nurse witnessed the resident sort of hopping over alarm		
without setting it off. It was also reported to the Nurse that		
Resident #2 was seen putting her walker over the mat and		
alarm and trying to step over it. Resident #2 made it into		
Resident #1's room before she was redirected. This is a fall		
hazard and intervention needs to be reevaluated as the		
intervention is ineffective for monitoring Resident #1's		
whereabouts as Resident #1 can easily navigate around it		
without setting it off.		
* On 10/5/21 at 5:35 a.m., Resident #1 continues to		
circumvent alarm at his doorway. Resident has been up to		
nurses station twice this shift and alarm did not sound.		
Alarm was on when checked.		
* On 10/17/21 at 2:15 p.m., a CNA opened door to		
resident's (Resident #2) door to pass ice and Resident #1		
was sitting in recliner with Resident #2 on his lap. Resident		
#1 had his hand up Resident #2's shirt. CNA told Resident #		

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	1 he was not supposed to be in there and told Resident #2		
	to get off of his lap. Resident #2 moved to her bed.		
	Resident #1 said he would not leave. CNA told the Nurse.		
	The Nurse stated she was walking down the hall and		
	CNA explained situation to her. Nurse entered the room		
	and saw Resident #1 sitting in Resident #2's recliner and		
	Resident #2 sitting on her bed. Nurse had Resident #1 get		
	up and go back into his room and then notified the Nurse		
	Manager. The Nurse Manager had Nurse bring Resident #1		
	up to nurses station to keep the residents apart and then		
	notified the Administrator and their Nurse Consultant. 15		
	minute checks were initiated. Administrator reporting		
	incident and Doctor was notified. Resident' #1's wife was		
	called without answer. Spouse returned call and was		
	notified at 7:30 a.m. on 10/18.		
	* On 10/24/21 at 11:51 a.m., Resident #1 continues on 15		
	minute checks due to history of entering other residents'		
	rooms, attempts to touch a woman inappropriately.		
	Resident has had no behaviors of this sort in the last 3 days.		
	Resident pleasant and cooperative. Ambulates with a front		
	wheeled walker from his room to the lobby area. He has		
	made no attempts of going any other places that these 2		
	areas. Continues to sit near nurse's station for meals.		
	Resident denies any concerns with this. Affect continues		
	flat. Speaks when spoken to. Denies any pain or any needs		
	at that time.		
	* On 11/7/21 at 9:02 a.m., Resident continues on one to		
	one supervision and 15 minute checks. Resident noted to		
	be more touchy and trying to get close to female staff. One		
	to one CNA came to this nurse to report this. Resident was		
	reminded to stay away from female residents.		
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Facility Administrator

Date

Citation Number: #5492 Facility Name: Northern Mahaska Specialty Care			Survey		Date: Decemi	ber 27, 2019
Facility Address/City/State/Zip 2401 Crestview Drive Oskaloosa, IA 52577		MW/DC				
Rule or		e of Violation	Class	Fine Amount		Correction date
	documented Resident #1 The following 15 Minute (the facility: * 10/17/21 4 p.m. to 10/1 minute checks were initia * 10/18(21) and 10/19(21) checks starting at 3:15 p.r on 10/18/21. It then show a.m. to 3:45 a.m * 10/20/21 9:30 a.m. to 3 * 10/20/21 from 4:00 p.m initialed. * 10/21/21 from 9:30 a.m * 10/21/21 from 9:30 a.m * 10/22/21 from 12:15 a.m were initialed. Then from checks were initialed. On resumed at 8:30 p.m. to 1 written next to the 8:30 p On top of this page the da by the 12:15 a.m. slot 10/ * 10/23/21 from 12:15 a.1 5:30 p.m. and from 6:00 p checks were initialed.	c)(overnight): showed initialed m. to 3:45 p.m. and at 11:50 p.m. wed initialed checks from 12:05 :45 p.m., all spots initialed. h. to 10/21/21 9:15 a.m. all spots to 3:45 p.m. all spots initialed. h. to 12:00 a.m. on 10/22/21. m. to 11:30 a.m. showed checks 2 p.m. to 8:00 p.m. showed this sheet it shows checks were 1:45 p.m., however the date m. slot documented 10/23 (21). ate 10/23/21 is written however				

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Facility Administrator

checks were initialed.

Citation Numl #5492	ber:				Date: Decemt	oer 27, 2019
Facility Name: Northern Mahaska Specialty Care Facility Address/City/State/Zip			Survey 10/20/21	Dates: -12/9/21		
2401 Crestvie Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	e of Violation	Class	Fine An	nount	Correction date
	 were initialed. No further sheets were produring the missing times. A Nursing Facility Verbal I Assessment Tool dated 3/ who filled out the tool, ga Imagine you are in a privative kissed, hugged and touch their pants and asks you to you think this person is as documented response was was What would you do? response was: I don't knot informed consent was: An sexual acts and the ability Staff documented yes for date on the signature lines. There was no Progress Not regarding any incident. A Nursing Facility Verbal I Assessment Tool dated 3/ who filled out the tool, ga Imagine you are in a privative kissed, hugged and touch their pants and asks you to you think this person is as 	Informed Sexual Consent /16 and dated 12/22/20 by staff ave the following scenario: ate place with a person you have ed before. Now this person unzips to put your hand inside. What do sking you to do? Resident #1's as: having sex. The next question Resident #1's documented ow. One of 4 principles of sexual in awareness of the nature of y to choose to engage or abstain. Resident #1. Staff did not sign nor e provided for them.				

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Facility Administrator

Citation Numb #5492	er:			Date: Deceml	ber 27, 2019
Facility Name: Northern Mahaska Specialty Care			Survey I 10/20/21		
Facility Addres	ss/City/State/Zip		10/20/21	12,0721	
Oskaloosa, IA		MW/DC			
Rule or Code Natur		e of Violation	Class	Fine Amount	Correction date
Section					

question was: What would you do? Resident #1's		
documented response was: touch them. Resident's BIMS		
score was documented at a 7 indicating severe cognitive		
impairment.		
There was no Progress Note on or around this date		
regarding any incident.		
A Nursing Facility Verbal Informed Sexual Consent		
Assessment Tool with development date of 3/16 was not		
dated by staff, gave the following question: Is there		
someone NOW that you can talk to about sex? If so, who is		
that person? Resident #1's documented response was yes,		
mother. To the question: Who do you think is in charge of		
making sexual decisions in your life?, Resident #1		
answered: my wife. Resident #1 answered yes to the		
questions: is it okay to pay money to have sex. Staff did not		
sign nor date on the signature line provided for them.		
There was no Progress Note on or around this date		
regarding any incident.		
A Nursing Facility Verbal Informed Sexual Consent		
Assessment Tool dated 3/16 and dated 9/7/21 by staff who		
filled out the tool, gave the following question: Is there		
someone NOW that you can talk to about sex? If so, who is		
that person? Resident #1's documented response was yes,		
wife. To the question: Who do you think is in charge of		
making sexual decisions in your life?, Resident #1		
answered: myself. This tool gave the following scenario:		
Imagine you are in a private place with a person you have		
Imagine you are in a private place with a person you have		

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Citation Numb #5492	er:			Date: Decem	ber 27, 2019
Facility Name: Northern Maha	aska Specialty Care	-	Survey I 10/20/21		
Facility Addres	ss/City/State/Zip			- 12/3/2 1	
Oskaloosa, IA		MW/DC			
Rule or Code	Natur	e of Violation	Class	Fine Amount	Correction date
Section					

kissed, hugged and touched before. Now this person unzips their pants and asks you to put your hand inside. What do you think this person is asking you to do? Resident #1's documented response was: to have sex. The next question was: What would you do? Resident #1's documented response was: wouldn't do anything. The 4 principles of sexual consent questions were left blank and staff did not sign or date on the provided signature line.		
There was a documented incident on 9/6/21 in this resident's Progress Notes.		
The Clinical Census printed on 11/18/21 at 9:11 a.m., documented Resident #1 was admitted on 11/6/18 into room #210 and stayed in that room until he was moved into room #201 on 10/21/21 and moved again to room #217 on 10/28/21.		
2. A MDS with an ARD of 7/28/21, documented Resident #2's diagnoses included unspecified dementia with behavioral disturbance, anxiety, and depression. The resident's BIMS score was 9 which indicated moderate cognitive impairment. Resident #2 was independent with transfers, and walking in room and required supervision for bed mobility.		
A Care Plan for Resident #2 included the following focuses and directed staff to do the following interventions: a. A focus area with a revision date of 2/13/19, documented Resident #2 had questionable recall related to		

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Facility Administrator

Citation Numb #5492	er:			Date: Decem	ber 27, 2019
Facility Name: Northern Maha	ska Specialty Care		Survey I		
Facility Addres	ss/City/State/Zip		10/20/21	-12/3/21	
2401 Crestviev Oskaloosa, IA		MW/DC			
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date

	dementia, depression, potential medication side effects.		
	The goals revised on 2/10/21, documented Resident #2		
	would remain oriented to self/family during the review		
	period. Interventions with a date initiated on 10/17/21,		
	directed staff that Resident #2 has allowed Resident #1 to		
	fondle her, her family is aware and Resident #2 often		
	seeks out Resident #1 for sexual attention. Staff are to		
	redirect her as needed. Interventions dated 8/12/17,		
	directed staff to provide Resident #2 with diversional		
	activities as allowed, to re-orient/re-direct her as she would		
	allow and to validate her thoughts/feelings when she		
	exhibited frustration related to impairment.		
	b. A focus area revised on 9/26/21, documented Resident		
	#2 used safety devices and that she had a wander guard.		
	The goal for Resident #2 dated 9/26/21, was resident would		
	remain safe in her environment. An intervention dated		
	9/26/21, directed staff that Resident #2 had a wander		
	guard.		
	c. A focus area revised on 11/25/19, documented Resident		
	#2 displayed socially disruptive behavior and would		
	on occasion take items that belong to her roommate.		
	Resident #2's goal revised on 2/10/21, was Resident #2		
	would decrease her episodes of disruptive behaviors by		
	50%. Interventions dated 11/26/19, directed staff to visit		
	with her and provide diversional activities, to monitor and		
	document her behavior, and to talk with her in a calm voice		
	when her behavior is disruptive.		
	d. A focus area revised on 8/4/21, documented Resident #2		
	exhibited signs of disorganized thinking and		
	irrelevant conversation. The goal for Resident #2 dated		
	8/4/21, was Resident #2's symptoms of delirium would		
<u>.</u>		 	Dege 77 of 443

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Citation Numb #5492	per:				Date: Deceml	ber 27, 2019
Facility Name: Northern Mahaska Specialty Care Facility Address/City/State/Zip			Survey 10/20/21	Dates: I-12/9/21		
2401 Crestvie Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	e of Violation	Class	Fine An	nount	Correction date
	8/4/21, directed staff to riconsciousness to the doct A Progress Note dated 10, a CNA opened Resident #2 and Resident #1 was sittir Resident #2 on his lap. Re Resident #2's shirt. CNA re he was not supposed to b to she needed to get out of the bed. The CNA told Res #1 said he would not leave nurse. The Nurse stated sh the CNA explained the situ she entered the room and Resident #2's recliner with Nurse stated she had Resi his room. The Nurse then notified the Nurse Manag 1 to the nurse's station to Nurse Manager then notif Nurse Consultant. New BI with a BIMS of 5 (severe cominute checks were initia incident and the doctor w was called and notified of A note for Incident # 2264	/17/21 at 2:15 p.m., documenter 2's door to her room to pass ice ag in Resident #2's recliner with sident #1's hand was up eported she told Resident #1 th e in there and told Resident #2 of his lap. Resident #2 moved to sident #1 to leave and Resident e. The CNA then notified the he was walking down the hall a uation to her. The Nurse stated d saw Resident #1 sitting in n Resident #2 walking to her be dent #1 get up and go back to went to the nurse's station and er. The nurse brought Resident keep the resident's apart. The fied the Administrator, and the MS assessment was completed cognitive impairment). Fifteen ted. Administrator was reportir as notified. Resident #2's son	ed at o nd d. i #			

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Facility Administrator

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Num #5492	ıber:				Date: Deceml	ber 27, 2019
	haska Specialty Care		Survey 10/20/21		<u>II</u>	
2401 Crestvie		MW/DC				
Oskaloosa, I	A 52577					
Rule or Code Section	Natur	e of Violation	Class	Fine A	Amount	Correction date
<u>.</u>				"		
	The following 15 Minute (the facility:	Checks sheets were provided by				
	* 10/17/21 4 p.m. to 10/1	.8/21 at 9:15 a.m.: showed 15				
	minute checks were initia					
	* 10/18/21 at 9:30 a.m. to checks were initialed as d	o 3:45 p.m., showed 15 minute				
	No further sheets were p					
	who filled out the tool, ga someone NOW that you of that person? Resident #2' son. To the question: Who making sexual decisions in answered: it would be me tool gave the following sc private place with a perso touched before. Now this asks you to put your hand person is asking you to do response was: nothing be next question was: What documented response was	'16 and dated 7/15/21 by staff we the following question: Is there can talk to about sex? If so, who is s documented response was: my o do you think is in charge of	there no is my This The			
	woman can become preg prevent pregnancy?	nan have sexual intercourse, the nant. What can you do to have sexual behaviors, such as				
		and if one person has an				

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Citation Numb #5492	per:				Date: Decemi	ber 27, 2019
	aska Specialty Care ss/City/State/Zip	-	Survey I 10/20/21			
2401 Crestviev Oskaloosa, IA	w Drive	MW/DC				
Rule or Code Section		e of Violation	Class	Fine A	mount	Correction date
	to prevent an infection? The 4 principles of sexual and staff did not sign or d line. There was no documente in Resident #2's Progress The Clinical Census printe documented Resident #2 400 hall to room #211 in t 3. A MDS with an ARD of 9 #15's diagnoses included respiratory failure with hy #15's BIMS score was 15 i Resident #15 was indeper and walking in room. A Care Plan for Resident # area and directed staff to a. A focus area dated 11/2 used safety devices. The g 8/16/21, was Resident #1 environment. Intervention that Resident #15 had an assist bar. An intervention	d on 11/18/21 at 9:13 a.m., moved from room #404 in the				

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Facility Name: Northern Maha	ska Specialty Care		Survey I		
Facility Addres	ss/City/State/Zip		10/20/21	-12/3/21	
2401 Crestviev Oskaloosa, IA		MW/DC			
Oskalousa, IA	52511				
Rule or		м		Fine Amount	Correction
Code	Natur	e of Violation	Class		date
Section					

	A Progress Note dated 2/9/21 at 10:43 a.m., documented it			
	was reported to the nurse last night, that Resident #1			
	made inappropriate comments to Resident #15. Resident			
	#15 stated Resident #1 walked into the doorway of			
	Resident #15's room and asked if she (Resident #15)			
	wanted his (Resident #1's) penis. Resident #15 replied no to			
	which Resident #15 replied "oh, I thought you did". They			
	talked for a little while and then Resident #1 went back to			
	his room. When the Social Service staff talked with Resident			
	#15, Resident #15 stated Resident #1 did not make her			
	feel unsafe and she was not offended by his comments but			
	she would like to move rooms just so she isn't directly			
	across the hall from him. We are moving Resident #15			
	immediately (to a different hall).			
	A Progress Note dated 10/26/21 at 3:33 p.m., documented			
	Social Services met with Resident #15 regarding a past			
	incident that had occurred. Staff asked if there was ever a			
	time she felt uncomfortable with another resident.			
	Resident #15 stated she was in her other room and			
	Resident #1 walked into her room while she was watching			
	TV and asked her if she wanted it. Resident #15 pointed at			
	her private area. Staff asked what she meant by this and			
	she shared his penis/dick. Resident #15 stated no and that			
	Resident #1 stood there and then left. Staff asked Resident			
	#15 if his clothes were on and Resident #15 stated yes. She			
	stated she was (wasn't) sure if his privates were out or not.			
	Staff asked if she felt safe and Resident #15 stated she did.			
	Resident #15 stated she would respond better. She stated			
	she was shocked but now she is aware and won't let that			
	happen. She stated she goes to activities where he is and is			
<u>u</u>	μ	r	r	Page 81 of 11

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Facility Administrator

Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Number: #5492 Facility Name: Northern Mahaska Specialty Care Facility Address/City/State/Zip 2401 Crestview Drive Oskaloosa, IA 52577		MW/DC	Survey . 10/20/21			ber 27, 2019	
Rule or Code Section		e of Violation	Fine Amount Class		mount	Correction date	
	 knows where he is and new would talk to Social Services stated she felt bad it took encouraged to tell from h did. Staff thanked residen The Clinical Census printer documented Resident #15 200 hall to a room in the 3 4. A MDS with an ARD 1/2 diagnoses included non-A and heart failure. Residen indicated intact cognition limited assist of 1 with bein room. A Care Plan for Resident #1 and directed staff to do thas and heart fail to do thas and sefety devices. The gree Resident #13 was she would assist and a specific to that Resident #13 had a specific to that Residen	d on 11/18/21 at 9:14 a.m., 5 moved from room #209 in the 300 hall on 2/9/21. 25/21, documented Resident #13's Izheimer's disease, diabetes, t #13's BIMS score was 13 which . Resident #13 required d mobility, transfers and walking 413 included the following focuses he following interventions: 3/21, documented Resident #13 goal revised on 5/26/21, for ald remain safe in her hs dated 1/28/21, directed staff pecialty call light and had an intervention dated 9/8/21					

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b. A focus area revised on 8/30/21, documented Resident

#13 was an elopement risk/wanderer related to disoriented to place, impaired safety awareness and wandering aimlessly. The goals initiated 8/24/21 were

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Numb #5492	er:			Date: Decem	ber 27, 2019		
Facility Name: Northern Maha	ska Specialty Care			Survey Dates: 10/20/21-12/9/21			
Facility Address/City/State/Zip			10/20/21-12/9/21				
2401 Crestviev Oskaloosa, IA		MW/DC					
Oskalousa, IA	52511						
Rule or		м		Fine Amount	Correction		
Code	Natur	e of Violation	Class		date		
Section							

p			
	Resident #13 would be maintained safely through the		
	review date and she would not leave the facility		
	unattended through the review date. Interventions dated		
	8/24/21 directed staff to approach Resident #13 positively		
	in a calm, accepting manner, to provide diversional		
	activities, and she wears a wander alert. An intervention		
	dated 8/30/21, directed staff to distract her from		
	wandering by offering pleasant diversions, structured		
	activities, food, conversation, TV shows and books.		
	c. A focus area dated 1/28/21, documented Resident #13		
	had impaired cognitive function/dementia or impaired		
	thought process related to dementia. The goal revised on		
	5/26/21, was Resident #13 would be able to communicate		
	basic needs on a daily basis through the review date.		
	Interventions dated 1/28/21, directed staff to communicate		
	with Resident #13, her family and caregivers regarding her		
	capabilities and needs, to use her preferred name, identify		
	themselves at each interaction, face her when speaking and		
	make eye contact, reduce an distractions, provide her		
	with necessary clues, stop and return if she is agitated, and		
	keep routine consistent and try to provide consistent		
	caregivers as much as possible in order to decrease		
	confusion. An intervention dated 3/5/21, directed staff that		
	Resident #13 had a sign to help locate her room.		
	A Progress Note dated 9/6/21 at 3:00 p.m., documented it		
	was reported to the Nurse that another resident came up		
	behind this resident and touched her breasts. At the time		
	this was reported the other resident had gone back to his		
	room and this resident (Resident #13) remained in the		
	dining room visiting with other female residents.		
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Facility Administrator

Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Numb #5492	er:			Date: Decem	ber 27, 2019		
Facility Name: Northern Maha	ska Specialty Care	-		Survey Dates: 10/20/21-12/9/21			
Facility Address/City/State/Zip			10/20/21-12/9/21				
2401 Crestview Drive Oskaloosa, IA 52577		MW/DC					
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date		

A Progress Note on 9/7/21 at 10:00 a.m., documented the Social Service Coordinator met with Resident #13		
regarding the possible incident that occurred over the		
weekend. Resident #13 willingly went through the sexual		
consent. Resident #13 stated there was no one who		
touched her and if there was they would be on the ground.		
Sexual consent was filed in documents.		
The Clinical Census printed on 11/18/21 at 9:17 a.m.,		
documented Resident #13 resided in the 100 hall.		
5. A MDS with an ARD of 6/16/21, documented Resident		
#14's diagnoses included diabetes, bipolar disorder and		
Post Traumatic Stress Disorder (PTSD). Resident #14's BIMS		
score was 15 indicating intact cognition. Resident #		
14 required supervision of 1 with bed mobility, extensive		
assist of 2 for transfers, walking in room did not occur, and		
was independent with locomotion on and off the unit.		
A Care Plan for Resident #14 included the following focus		
and directed staff to do the following interventions:		
a. A focus area dated 9/10/21, documented Resident #14		
had a history of physical or emotional trauma. The goal		
revised on 9/10/21, was she would not have a trauma		
triggered event. Interventions revised on 11/1/21, directed		
staff that Resident #14 de-escalation interventions were		
taking deep breaths, talking to someone about her needs		
and reminding herself that it was better now.		

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Facility Administrator

Date

Citation Num #5492	nber:				Date: Decemi	oer 27, 2019
	e: haska Specialty Care ress/City/State/Zip	-	Survey 10/20/21	Dates: -12/9/21	<u>J</u>	
2401 Crestvi Oskaloosa, I	ew Drive	MW/DC				
Rule or Code Section	Natur	e of Violation	Class		Amount	Correction date
	-	d on 11/18/21 at 9:16 a.m., 4 resided in room #209 in the 200				
	6. A MDS with an ARD of #16's diagnoses included disorder, and seizure diso was 15 indicating intact c extensive assist of 1 with for transfers and locomot walking in room did not o					
	A Care Plan for Resident #16 included the following focus and directed staff to do the following interventions: a. A focus area dated 7/21/21, documented Resident #16 was at risk for impaired communication related to visual impairment and hearing difficulty. The goal revised on 6/2/21, was she would be able to interact with peers, family and staff. Interventions revised on 7/21/20, directed staff Resident #16 can understand simple direct communication, and to speak to her in a low, clear voice to increase her chance of hearing.					
		d on 11/18/21 at 9:16 a.m., 5 resided in room #208 in the 200	5			
	#17's diagnoses included and non-Alzheimer's dem	10/19/21, documented Resident cerebral infarction, diabetes entia. Resident #17's BIMS score ognition. Resident #17 required				

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Facility Administrator

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Num #5492	ber:				Date: Decemi	ber 27, 2019
	: aska Specialty Care ess/City/State/Zip		Survey 10/20/21			
2401 Crestvie Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	e of Violation	Class	Fine A	mount	Correction date
	in room. A Care Plan for Resident # and directed staff to do th a. A focus area dated 9/24 experienced unwanted se 1 on 9/18/21. The goal da free of sexual advances of Resident #1. Intervention staff that Resident #17 is don't want to interact wit room change and will avo sunroom. A Progress Note dated 9/2	d mobility, transfers and walking #17 included the following focus he following interventions: 4/21, documented Resident #17 exual advances from Resident # ited on 9/24/21, was she would be r unwanted interaction with s revised on 9/24/21, directed able to say no and state when I sh other residents, and she had a id hanging out in 200 hall 18/21 at 10:00 a.m., documented with resident and she stated a				
	male resident had kissed shouldn't be doing that an it". Resident #17 stated he shirt. Resident #17 stated told him not to do that an intervened. Doctor aware to significant other regard A Progress Note dated 9/2 Resident #17 was sitting t resident (Resident #1) wa	her head. She told him he nd he told her "don't worry about e then put his hand down her she put her hand over his and nd he responded ok. Staff e of situation and message was out				

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Facility Administrator

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

hand down her shirt. The male resident was immediately removed from lounge and taken to the nursing station.

Citation Numb #5492	ber:				Date: Deceml	oer 27, 2019
	aska Specialty Care	-	Survey I 10/20/21			
2401 Crestvie Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	e of Violation	Class	Fine A	mount	Correction date
	Assistant Director of Nurs and the doctor was notified A Progress Note dated 9/2 the Social Service worker talked with her about what Resident #17 shared that happened since. Staff ask #17 answered yes. Resided avoid the man if she saw A Progress Note dated 9/2 the Social Service worker asked how she was doing Resident #17 said she was concerns. The Clinical Census printed documented Resident #12 time of the incident and r 8. A MDS with an ARD of 8 #18's diagnoses included diabetes, and anxiety. Thi which indicated moderate	20/21 at 10:30 a.m., documented met with Resident #17 and at occurred over the weekend. a male toucher her and it had not ed her if she felt safe and Resident ent #17 stated she would just him. 21/21 at 8:30 a.m., documented spoke with Resident #17 and and if she had any concerns. s doing good and did not have any d on 11/18/21 at 9:18 a.m., 7 resided in the 400 hall at the noved to the 300 hall on 10/4/21. 8/11/2021, documented Resident non-Alzheimer's dementia, s resident's BIMS score was 9 e cognitive impairment. Resident # vith set up help for bed mobility.				

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Facility Administrator

Citation Numb #5492	er:			Date: Decem	ber 27, 2019		
Facility Name: Northern Maha	aska Specialty Care	•		Survey Dates: 10/20/21-12/9/21			
Facility Address/City/State/Zip 2401 Crestview Drive				10/20/21-12/3/21			
Oskaloosa, IA		MW/DC					
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date		

A MDS with an ARD of 5/12/2021, documented Resident		
#18's diagnoses included coronary artery disease,		
diabetes, and anxiety. This resident's BIMS score was 8		
which indicated moderate cognitive impairment. Resident		
#18 required supervision with set up help for bed mobility.		
This resident was independent with transfers and		
ambulation. This MDS was the most recent MDS completed		
prior to the incidents below.		
A Care Plan for Resident #18 included the following focus		
and directed staff to do the following interventions:		
a. A focus area revised on 3/4/21, documented Resident		
#18 enjoyed going outside and visiting with others.		
Resident #18 refused to social distance during activities.		
The goal revised on 5/12/21, was he would voice		
satisfaction with activity involvement. Intervention dated		
on 3/4/21, directed staff that Resident #18 would be		
educated on social distancing.		
b. A focus area revised on 5/27/21, documented Resident		
#18 had displayed socially inappropriate/disruptive		
behavior by touching a females breast. The goal dated		
5/27/21, was this resident would not display inappropriate		
or disruptive behaviors. An intervention dated 5/25/21,		
directed staff to assist this resident to another part of the		
building if staff see him wandering into another resident's		
room. Interventions dated 5/27/21, directed staff to		
monitor and document resident's behavior and Social		
Services was to evaluate and visit with Resident #18 as		
needed.		

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Oskaloosa, IA 52577 Rule or Code Natur Section		re of Violation	Class	Fine Amount	Correction date
	A Progress Note dated 5/	27/21 at 5:17 p.m., Social Services			

A Progress Note dated 5/2//21 at 5:1/ p.m., Social Services		
documented that on 5/25/21. Resident #18 had touched		
Resident #22's breast. There were no injuries and Resident		
#22 was not bothered by the encounter. Staff were told		
to monitor Resident #18's interactions with other residents.		
Social services spoke with Resident #18 on the day of the		
incident and told him not to display those behaviors.		
Resident #18 admitted to grabbing Resident #22's breast		
and stated he would not do it again. Resident's POA was		
notified.		
A Progress Note dated 5/28/21 at 10:30 a.m., nursing		
documented that she had spoken to Resident #18 regarding		
not going down the hallway and visiting with residents.		
Resident was informed he needed to be cautious of visiting		
in rooms due to not everyone being so accepting of his		
presence in their bedroom. Resident stated he did not even		
go down to anyone's room anymore. Social Services was		
present during the conversation.		
A Progress Note dated 5/28/21 at 10:40 a.m., Social		
Services documented she was informed that Resident #19		
had concerns that Resident #18 and Resident #1 had been		
in her room at some point in the past. Resident #19 could		
not say for sure when but it wasn't on that day. Social		
Services asked Resident #18 to not go into Resident #19's		
room and reminded him to knock before entering anyone's		
room. He stated that he understood. A stop sign was put on		
Resident #19's door.		
A Progress Note dated 5/28/21 at 4:30 p.m., documented		
that resident was witnessed wandering down 100 hall in		

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Citation Numb #5492	er:			Date: Decem	ber 27, 2019	
Facility Name: Northern Maha	aska Specialty Care		Survey Dates: 10/20/21-12/9/21			
-	ss/City/State/Zip			- 12/3/2 1		
2401 Crestview Drive Oskaloosa, IA 52577		MW/DC				
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	1		1	1
	the direction of Resident #19's room. The nurse followed			
	the resident back to his room to again reiterate the			
	importance in not entering anyone's room that may be			
	unwanted. He then shoved the nurse out of the room,			
	attempted to throw his walker at the nurse and then			
	slammed the door in the nurse's face. DON and the doctor			
	were informed of the incident. No new orders.			
	A Progress Note dated 5/28/21 at 5:21p.m., documented			
	the POA was aware of resident's behaviors today and is			
	planning on contacting resident and having discussion with			
	him regarding privacy and unwanted visits to female			
	residents.			
	The Clinical Census printed on 11/18/21 at 9:19 a.m.,			
	documented Resident #18 resided in the 400 hall at the			
	time of the incident and moved to Room 217 in the 200 hall			
	on 8/1/21.			
	9. A MDS with an ARD of 4/2/21, documented Resident			
	#19's diagnoses included non-Alzheimer's dementia,			
	diabetes, and anxiety. A BIMS score of 7 indicated Resident			
	#19 had severely impaired cognition. Resident #19			
	required limited assist of 2 for bed mobility, extensive assist			
	of 2 for transfer and extensive assist of 1 for locomotion			
	on the unit.			
	A Care Plan for Resident #19 included the following focus			
	and directed staff to do the following interventions:			
	a. A focus area revised on 6/16/21, documented Resident			
	#19 required staff assistance with mobility related to			
U		1	μ	Baga 90 of 11

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Facility Administrator

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

er:			Date: Decemi	ber 27, 2019		
ska Specialty Care			Survey Dates:			
s/City/State/Zip			12/0/21			
52577	MW/DC					
			Fine Amount	Correction		
Natur	e of Violation	olation Class		date		
	ska Specialty Care s/City/State/Zip / Drive 52577	ska Specialty Care s/City/State/Zip / Drive	ska Specialty Care ss/City/State/Zip / Drive 52577 MW/DC	Decemination Survey Dates: Ska Specialty Care Survey Dates: 10/20/21-12/9/21 10/20/21-12/9/21 MW/DC Fine Amount		

left ankle fracture The goal revised on 7/7/21, was she		
would improve her ability to ambulate. Interventions		
revised on 6/16/21, directed staff that Resident #19 was		
unable to put weight on her left lower extremity and		
required a wheel chair for long distance mobility.		
b. A focus area revised on 9/9/21, documented Resident		
#19 had impaired cognitive function/dementia impaired		
thought processes related to dementia. The goal revised on		
9/9/21, was she would be able to voice basic needs on a		
daily basis through the review date. Interventions dated on		
9/9/21, directed staff to communicate with Resident #19,		
her family and caregivers regarding her capabilities and		
needs. A stop sign to doorway to keep others out per her		
request.		
A Progress Note dated 5/20/21 at 5:35 p.m., documented		
Resident #19's spouse was here (at the facility) and very		
upset. Resident's spouse said that another resident had		
gone into Resident #19's room and kissed her on the lips.		
He (the husband) wanted to file a complaint. Call placed to		
on call staff and they said they would notify the DON.		
A Progress Note dated 5/21/21 at 12:06 a.m., documented		
resident had no further encounters with other resident that		
shift and was currently in her room resting with eyes closed		
and call light within reach.		
A Progress Note dated 5/28/21 at 10:00 a.m., documented		
a CNA approached Resident #19 in regards to changed		
demeanor. Resident #19 reported to the CNA that Resident		
#18 and Resident #1 were in her room that morning and		
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Facility Administrator

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Numb #5492	er:			Date: Decem	ber 27, 2019
Facility Name: Northern Mahaska Specialty Care			Survey Dates: - 10/20/21-12/9/21		
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8				
	made unwanted sexual remarks toward her. The Nurse			
	then responded to the report from the CNA by assessing			
	and visiting resident with Social Services. Resident voiced			
	concerns related to unwanted sexual remarks from			
	alternative male residents. Resident #19 stated they have			
	entered her room on multiple occasions and make remarks			
	such as she was too cute and they wished they could get			
	into her pants. Resident #19 was once again educated on			
	using call light if the men ever enter her room unwantedly			
	and a stop sign was placed at residents doorway. The Nurse			
	spoke with the Nurse that was scheduled down Resident			
	#19's hall and that Nurse said she had been on the hall all			
	morning but had not seen either resident down that hall.			
	A Progress Note dated 5/28/21 at 10:59 a.m., documented			
	Social Services was informed Resident #19 had concerns			
	that Resident #18 and Resident #1 had been in her room at			
	some point in the past. She couldn't say for sure when but			
	it was not on that day. She spoke with Resident #18 and asked him not to go into Resident #19's room again and to			
	knock before entertaining anyone's room. Resident #18			
	stated he understood. A stop sign was placed on Resident #18			
	19's door immediately.			
	The Clinical Census printed on 11/18/21 at 9:15 a.m.,			
	documented Resident #19 resided in the 200 hall at the			
	time of the kissing incident and was moved to the 100 hall			
	on that day (5/20/21).			
	10. A MDS with an ARD of 9/15/21, documented Resident			
	#22's diagnoses included non-Alzheimer's dementia,			
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Oskaloosa, IA 52577		MW/DC				
Rule or Code Section	Nature of Violation		Class	Fine Am	nount	Correction date
		. Resident #22's BIMS score was 2 e impairment. Resident #22				

required extensive assist of 1 for bed mobility and		
extensive assist of 2 for transfers and walking in room.		
A Care Plan for Resident #22 included the following focus		
and directed staff to do the following interventions:		
a. A focus area revised on 3/20/20, documented Resident		
#22 was an elopement risk/wanderer related to dementia		
and wandering. The goal revised on 6/16/21, was she		
would not leave the facility unattended. Interventions		
revised on 3/6/20, directed staff that Resident #22 has a		
wander guard on her right wrist and to distract her from		
wandering by offering pleasant diversions, structured		
activities, food and conversation.		
b. A focus area revised on 3/9/20, documented Resident		
#22 had difficulty expressing her ideas or wants. The		
goals revised on 6/16/21, was she would be able to express		
her ideas or wants and would be able to interact with her		
peers, family and staff. Interventions dated on 2/26/20,		
directed staff to allow her plenty of time to respond, she		
could best understand simple, direct communication, to		
provide a quiet environment for Resident #22 when		
discussing important issues and to speak to her in a low,		
clear voice to increase her chances of hearing.		
A Progress Note dated 5/25/21 at 2:31 p.m., documented a		
staff member was passing laundry to Resident #22 and		
saw Resident #18 was grabbing her left boob and asking if		
she liked it. The staff member heard Resident #22 say		

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2401 Crestview Drive Oskaloosa, IA 52577		MW/DC			
Oskalousa, IA	52511				
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yes. Staff called out Resident #18's name and Resident #18	
told Resident #22 he had to go. Resident #18 then asked	
the staff member how his day was going. The staff member	
told Resident #18 that he could not enter ladies room and	
do that. Resident #18 apologized and left the room. The	
staff member then told the nurse. The Nurse went to	
Resident #22 and asked if she was ok. The resident smiled	
and said yes. The Nurse assessed the resident's left	
breast. There were no marks. The Nurse and Social Services	
went to talk with Resident #18. Resident #22's	
daughter was notified of incident. The daughter laughed	
and said OK as long as mom was happy and not injured.	
Informed daughter they would be monitoring Resident #18	
from entering Resident #22's room. Resident #22's	
daughter had no concerns.	
The Clinical Census printed on 11/18/21 at 9:19 a.m.,	
documented Resident #22 resided in the 400 hall at the	
time of the incident and still resided there at the time of	
the survey.	
An undated facility floor plan provided by the facility,	
showed the room numbers of each hall. Observations	
throughout the survey, revealed that all four hallways were	
open to the residents and these hallways did not have	
closed or locked doors from the points of entry to the	
hallways from the nurse's station.	
In an interview on 10/20/21 at 3:41 p.m., Resident #1's wife	
stated the problem with the facility was they have been	

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2401 Crestviev	v Drive				
Oskaloosa, IA	52577	MW/DC			
Rule or		J.		Fine Amount	Correction
Code Nature		e of Violation	Class		date
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so lax about what they are doing. She stated the prior DON said it was consensual with the incidents. She stated they put her husband on some medications, Depakote, probably 1-1 ½ months prior then increased it. She was told they were going to put an alarm in his doorway to let them know when he went out of his room. Lots of changes with administration. In June he had increased behaviors with mood swings and sexual thoughts. He was placed on an antibiotic for a UTI (urinary tract infection). They were putting him up by the nurse's station and that had been helping. They wanted to move him to one of their sister facilities and she told them no. She said about 1 ½ months ago they called her and told her he had touched another resident's breast and then called her back and said he hadn't. She felt a lot of his behaviors had been related to COVID 19 and being stuck in his room, eating in his room, etc. On 10/20/21 at 5:14 p.m., Resident #2's son, stated the facility had called him and said they went in to give his mother ice chips. The son stated the facility told him a male was in his mother's room and the male was touching his		
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mother ice chips. The son stated the facility told him a male was in his mother's room and the male was touching his		
was in his mother's room and the male was touching his	-	
	<u> </u>	mother and his mother was touching the male resident.
The facility was going to monitor. The son was not aware of		
any incidents before this. He asked how close his mother's		
room was from the male resident and he was told she was		
across the hall from him. He stated hopefully they got it		
under control. They were doing 15 minute checks. He		
stated he was kind of befuddled when they told him about		· -
it and then they had asked if he had any questions. He told		

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	them no. He stated overa his mother likes it there.	II the facility does a good job and				
	Resident #1 and Resident rooms. The rooms were a An observation on 10/21, Resident #2 remained in I resident next to the door Resident #2's recliner was Resident # 2's roommate recliner next to the windo room sitting with another above his door and did no came on when alarm was This resident's male room to be asleep. The roomma	/21 at 9:20 a.m., revealed that #2 were in their respective across the hall from each other. /21 at 11:00 a.m., revealed that her room. She was the first upon entrance in to the room. s closer to the door than her bed. appeared to be asleep in her bw. Resident #1 was in the dining r male resident. The alarm was bt sound at the door. A red light s walked under but did not sound. nmate was in his bed and appeared ate was the second resident from esident #1 was the first resident m).				
	Resident #1's room. The a station only and only soun doorway. The alarm soun On 10/21/21 at 12:29 p.n when asked about Reside Depakote once. He stated good on Depakote nor wa The MD stated he didn't k	n., the DON walked in and out of alarm sounded at the nurse's nded when the DON was in the aded for 5 seconds. n., the Medical Director (MD), ent #1, stated he did increase the d to be honest the literature isn't as it good with female hormones. know what the answer was. He did ife wanted resident moved.				

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Other facilities were hesitant to take him because of his	
behaviors. He stated there are a lot of dependent adults	
there at the facility. The facility was doing a lot of checks on	
Resident #1. The MD stated Resident #1 is sneaky. The	
MD did not know about the door alarm. He stated they had	
been trying to get Resident #1 moved. He stated his	
resignation date was 10/31/21 and the next Medical	
Director could try something. He stated it was a hard	
behavior to quantitate. He stated he hated to medicate	
people and felt the facility had put interventions in place.	
He did not want to be completely unrealistic to say it will be	
100% effective. The biggest thing was they needed to move	
the resident and the wife was not supportive. The MD also	
did not want to move issues to another facility. He stated	
the literature is not good and anecdotal. The MD stated he	
needed to protect other residents too and a lot of it was	
trial and error, he state he was just trying to find the best	
combination. MD was asked about the female residents	
that were on the timeline provided by the facility undated	
list of Resident #1's current interventions. He stated that	
Resident #13's reliability was questionable. He believed	
that she would defend herself. The MD stated Resident #13	
had said if Resident #1 would have touched her breasts she	
would have kicked him. The MD stated that interview	
with staff they didn't really know if they did see it as pillars	
were in the way. In regards to Resident #17, he stated	
that he would definitely trust Resident #17's account. In	
regards to Resident #2, the MD stated she was not	
completely reliable. He was told that she was reciprocating	
in that instance. The MD stated Resident #2 is an	
	behaviors. He stated there are a lot of dependent adults there at the facility. The facility was doing a lot of checks on Resident #1. The MD stated Resident #1 is sneaky. The MD did not know about the door alarm. He stated they had been trying to get Resident #1 moved. He stated his resignation date was 10/31/21 and the next Medical Director could try something. He stated it was a hard behavior to quantitate. He stated he hated to medicate people and felt the facility had put interventions in place. He did not want to be completely unrealistic to say it will be 100% effective. The biggest thing was they needed to move the resident and the wife was not supportive. The MD also did not want to move issues to another facility. He stated the literature is not good and anecdotal. The MD stated he needed to protect other residents too and a lot of it was trial and error, he state he was just trying to find the best combination. MD was asked about the female residents that were on the timeline provided by the facility undated list of Resident #1's current interventions. He stated that Resident #13's reliability was questionable. He believed that she would defend herself. The MD stated Resident #13 had said if Resident #1 would have touched her breasts she would have kicked him. The MD stated that interview with staff they didn't really know if they did see it as pillars were in the way. In regards to Resident #17's account. In regards to Resident #2, the MD stated sew as not completely reliable. He was told that she was not completely reliable. He was told that she was reciprocating

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Date

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Facility Name: Northern Mahaska Specialty Care Facility Address/City/State/Zip		-	Survey - 10/20/21		
2401 Crestvi Oskaloosa, I		MW/DC			
Rule or Code Section	Natu	re of Violation	Class	Fine Amoun	t Correction date
	have liked it. On 10/21/21 at 1:03 p.m.	d if it was his mom he would not ., Resident #2 stated she had no			
	the resident across the habitation bothered her.	the facility. When asked about all, she stated he had never			
	(LPN), stated she was wal one of the incidents to do (Staff D) told her they had that Resident #2 was sitti was fondling Resident #2 between 2 p.m. and 5 p.r	, Staff I, Licensed Practical Nurse lking down the hall the day of o a skilled assessment. The CNA d a situation. Staff D told Staff I ng on Resident #1's lap and he 's breasts. It happened sometime n. Staff I entered the room and at			
	Resident #2 was walking then Resident #2 sat dow 1 ½ feet between the rec I stated they got Resident	s sitting in the recliner and toward the foot of her bed and 'n on her bed. There was probably liner and the foot of the bed. Staff t #1 out of the room. She stated he his face. He didn't want to leave			
	times to get him up from Resident #1 her hand. Shi to his room. Staff I stated Staff I said Resident #2 se Resident #1 out of the ro	hey had to repeat themselves 3 the recliner. Staff I offered e stated he finally got up and went Resident #1 likes girls you know. eemed upset that they had taken om. Staff I felt that Resident #2 e stated they both are nice people.			
	Staff I stated that Resider	at #2 did not seem upset that between them. Resident #2 did not			

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Facility Administrator

Citation Number: #5492				Date: Decem	ber 27, 2019
Facility Name: Northern Mahaska Specialty Care			Survey I		
Facility Address/City/State/Zip			10/20/21	-12/3/21	
2401 Crestview Drive Oskaloosa, IA 52577		MW/DC			
Rule or Code Nature of Violation Section		e of Violation	Class	Fine Amount	Correction date

	verbalize anything. Staff I told Nurse Supervisor who was at			
	the nurse's station. We had Resident #1 come up and			
	sit at the nurse's station. He did not seem real thrilled but			
	he came up to the nurse's station. He's not much of a			
	talker. Staff I left the interventions to the Nurse Manager.			
	The intervention that they used immediately was to keep			
	him in line of site and put both of them on 15 minute			
	checks. She knew Resident #1 had left his room a couple of			
	times later that night. The alarm sounded. That's how they			
	knew. He went right back into his room. Staff I did not			
	know why they had not heard it earlier, maybe it was			
	because it was loud at the time.			
	On 10/25/21 at 3:05 p.m., Staff E, Registered Nurse (RN),			
	stated she worked the night of the incident. She wrote			
	where Resident #1 was on her hand because she didn't			
	have the paper. She would keep her eye on him. He mostly			
	stayed in his room. She stated Resident #1 did sit at the			
	nurse's station for a short time. Other than that she would			
	say 98 % of his time he was in his room. She stated he came			
	out a couple of times and they responded to his alarm.			
	She stated he was good with going back into his room. She			
	stated she saw him every 15 minutes. CNA's knew they			
	needed to know where he was. She stated he listens pretty			
	well when we tell him to please stay away from other			
	females.			
	On 10/25/21 at 3:10 p.m., Resident #17 stated Resident #1			
	had kissed her on the top of her head and then he put his			
	hand down her shirt, when asked if she had had any			
	advances made toward her. She told him no. He asked why			
<u>u</u>	,	μ	μ	Dogo 00 of 117

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Citation Numb #5492	er:	Da De				ber 27, 2019
Facility Name: Northern Mah	aska Specialty Care	-	Survey			
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2401 Crestviev Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	re of Violation	Class	Fine A	mount	Correction date
	s since then. He doesn't u On 10/25/21 at 3:45 p.m. started 15 minute checks out of the papers Staff E s mean any harm. He is a g understand. On 10/25/21 at 4:15 p.m. (NHA), stated he did not f anyone. He stated that Re Resident #1 didn't know y that the NHA had talked t	, the Nursing Home Administrator feel Resident #1 was harming esident #1 was really a nice guy. what he is doing and the ladies				

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Facility Administrator

11:35 p.m..

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

that she had provided. She concurred that 15 minute check

10/18/21 from 9:30 a.m. to 3:00 p.m. and from 4:00 p.m. to

10/19/21 from 4:00 a.m. to 10/20/21 at 3:45 p.m..

The DON stated 15 minute checks were not sustainable. On 10/25/21 at 5:18 p.m., the DON stated they had stopped doing the 15 minute checks for Resident #1 after the first 24 hours. The DON then had talked with the Nurse Consultant and was advised by the Nurse Consultant to still do the 15 minute checks. They then reinitiated the 15 minute checks on 10/20/21 for Resident #1. The 15 minute

10/22/21 from 11:45 a.m. to 1:45 p.m.. 10/23/21 from 6:15 a.m. to 1:45 p.m..

documentation was missing on:

Citation Numl #5492	ber:				Date: Decemi	oer 27, 2019
Facility Name Northern Mah	: naska Specialty Care		Survey			
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2401 Crestvie Oskaloosa, IA		MW/DC	-			
Rule or Code Section	Natur	e of Violation	Class	Fine A	mount	Correction date
	checks were done for 24 k	nours only for Resident #2.				
	An observation on 10/25/ #1 was in his room eating to a private room in the si station, Room 201. An observation on 10/25/ alarm sounded when he w #1 walked by the nurse's is started to walk back to his grabbed a female residen quickly. The female residen quickly. The female residen dining area. She smiled. Si Resident #1. Staff walked him. The alarm sounded a On 10/26/21 at 9:30 a.m., regarding Resident #1's do the end of 400 hall. Share The DON stated that staff the alarm. She stated that getting up there may not to hear the alarm. She stated i to see what they can do. I only male resident home, Down's Syndrome resider somewhere that residents asked about the observat	21 at 5:45 p.m. showed Resident supper. His room had changed ame hall closer to the nurse's 21 at 6:00 p.m., Resident #1's valked out of his room. Resident station then turned around and s room. He then turned and t's hand. Resident #1 moved ent was sitting at a table in the taff immediately separated back to Resident #1's room with again when they entered his room. , an observation was noted oor alarm could not be heard at d the information with the DON. would not always be able to hear t at 6:00 a.m. when people start be someone at the nurse's station ited this is why they started a 1:1 they have contacted their lawyer Maybe find housing for him in an such as a house that may have				

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Citation Num #5492	ber:				Date: Decemi	oer 27, 2019
Facility Name Northern Mar	e: naska Specialty Care	-	Survey	Dates: -12/9/21		
Facility Addre	ess/City/State/Zip		- 10/20/21	-12/3/21		
2401 Crestvie Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	e of Violation	Class	Fine A	mount	Correction date
	that Resident #1 moved faresponded immediately a On 10/26/21 at 10:20 a.m normally works on the 3-4 was aware of the 1-2 side aware of the issues with F not aware of recent incide behaviors. Staff A stated H Resident #1 is outside of t #1 had touched Resident stated he had asked Resid genitalia. She stated they Staff A stated Resident #1 nurse's station. She stated went off, but it sounded w go in and out. Staff A state because it could be anoth alarm. She stated if she is respond. Staff A stated in sitting in the front entryw asked him to go with her station. She stated he was time, she just knew he was female residents. Staff A sta about Resident #1. She sa not know. On 10/26/21 at 10:59 a.m	nd were right there. n., Staff A, CNA stated she 4 side (300 and 400 halls) but she e (100 and 200 halls) and was well Resident #1. Staff A stated she was				

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2401 Crestview Drive Oskaloosa, IA 52577		MW/DC				
Oskalousa, IA	52511					
Rule or Code Nature Section		м		Fine Amount	Correction	
		e of Violation	Class		date	

_		
	F had not witnessed any incidents. We did have a little lady	
	who told Staff F that Resident #1 had entered her room	
	3 or so times and it scared her. Staff F identified the little	
	lady as Resident #13. Staff F had noticed Resident #1	
	would hold Resident #2's hand. Staff F would gently	
	separate their hands and asked Resident #2 to hold on to	
	her walker. They (the facility) said they were care planned	
	and family was aware. 4 or 5 months ago Resident #2 was	
	standing in Resident #1's doorway. Staff F stated she did	
	not do 15 minute checks the night of 10/19/21. She knew	
	they had given the nurse's forms. She was not personally	
	approached to do 15 minute checks or fill out the papers.	
	She stated they were told eyes on Resident #1 at all times	
	and to keep him at the nurse's station. Redirect him and	
	keep him away (from female residents). Staff F stated you	
	cannot hear the alarm go off if you are in another	
	resident's room. They got rid of the floor mat they had	
	because Resident #1 had figured out he could step over it.	
	He could also shuffle the mat with his feet out of the way.	
	Staff F thought that in late evening during p.m. cares staff	
	might be in rooms and it would have been possible that no	
	one would hear his alarm. Staff F stated one time Resident	
	#2 tried to go over to his room. She picked up her walker	
	and tried to put it over the mat. They thought it was a fall	
	risk.	
	On 10/26/21 at 11:21 a.m., When asked about what she	
	witnessed on 10/17/21, Staff D, CNA, stated she was	
	passing water and noticed one resident's (Resident #2)	
	room door was closed. She opened the door and Resident	
	#1 was sitting in Resident #2's recliner with Resident #2 on	

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Facility Administrator

Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Numb #5492	er:			Date: Decem	ber 27, 2019	
Facility Name: Northern Maha	ska Specialty Care			Survey Dates: 10/20/21-12/9/21		
-	ss/City/State/Zip		10/20/21	- 12/ 3/2 1		
2401 Crestview Drive Oskaloosa, IA 52577		MW/DC				
Rule or				Fine Amount	Correction	
Code Section	Natur	e of Violation	Class		date	

his lap. Resident #1 had one hand up Resident #2's shirt and		
his other hand wrapped around her. Staff D told Resident		
#1 that he was not supposed to be in Resident #2's room.		
She told him c'mon, let's go and he said no. Staff D stated		
that the Nurse was coming down the hall at that time and		
Staff D told her that they had a situation in here. Staff D		
stated the nurse was able to get Resident #1 out. Resident		
#2 got off of his lap. Staff D stated Resident #2 was sitting		
on his lap willingly at the time. Staff D stated Resident #2		
came to Staff D about 5-6 minutes later and told Staff D		
that she was sorry she did that and she was not that kind of		
a lady. Staff D stated they basically 1:1'd resident the rest of		
the night. Staff D did not remember the alarm sounding the		
night of the incident. She stated you can hear the alarm if		
you are at the nurse's station. She stated they did move his		
room closer to the nurse's station. She stated they were to		
fill out 15 minute checks on him and make sure he went		
into his room.		
On 10/26/21 at 11:38 a.m., Staff C, Certified Medication		
Aide (CMA), stated she sees Resident #1 walking around		
in lobby mostly. He was on 15 minute checks for his		
behavior. She knew he had a doorbell that goes off at		
nurse's station and they did just move him closer to the		
nurse's station. She knew the doorbell had been there at		
least a week. She believed the doorbell was somewhat		
effective in keeping him away from female residents. Staff		
C stated Resident #1 gets bored so that's not probably great		
for him sitting alone. Staff C stated that during the day shift		
there's always someone at the nurse's station. She said that		
probably isn't the case on evening shift if Nurses are down		
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Date

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	aska Specialty Care		Survey 10/20/21			
Facility Addre	ess/City/State/Zip w Drive					
Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	e of Violation	Class	Fine A	mount	Correction date
	She said she did work night nights with at least 3 CNA him on that day. On 10/26/21 at 11:55 a.m Resident #1 is on frequent behaviors with females. S the lady across the hall. Sl Resident #2. Resident #2 of Resident #1 was standing her, grabbed her hand and reported it to a Nurse. Stat Nurse was. Staff H said it H H stated she redirected Re back to his room. Staff H s right thing. Staff H did not or what the Nurse did from he had a floor mat for an over it. He knew he had a sounded at the nurse's stat it if you are down the hall On 10/26/21 at 12:00 p.m #1 had come in to the roo Resident #1 showed her h wanted it. She said no. Re would want it. Resident # person who no longer wo quick the next day. She di	he state one time he was in with he identified the lady as was sitting in his recliner and over her. He reached down to d put it on his privates. Staff H iff H did not remember who the happened 3 or 4 weeks ago. Staff esident #1 and he went willingly stated the Nurse told her she did the Nurse told her she did there. Staff H stated she knew alarm but he knew how to step door alarm. The door alarm ation. Staff H stated you can't hear				

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Facility Administrator

Citation Num #5492	ıber:				Date: Decemb	per 27, 2019
	haska Specialty Care	-	Survey	Dates: -12/9/21		
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2401 Crestvi Oskaloosa, I		MW/DC				
Rule or Code Section	Natur	e of Violation	Class	Fine A	mount	Correction date
	then stated she did want On 10/26/21 at 12:25 p.m reported to her on 10/17, 15 minute checks. She wa returned they told her the again because DIA was th K stated one night Reside was in his underwear in b #1 is always in boxer shor down the hall. Staff K state peeing on the floor or ma kept moving. Staff K state #14) had come up to the man was standing 2 inche put her call light on and re reason she had her call lig and a man was standing c had been in the 100 hall w and didn't hear the alarm toward the nurse's station alarm was sounding she w resident lying in his bed c tell he was faking sleep. S	-				
	that on another night ear in his boxers at 6:00/6:15 out for Resident #1's geni but did not remember wh	what the date was. Staff K stated ly in the morning Resident #1 was a.m. and Resident #13 reached tals. Staff K stated she reported it ich Nurse was working or what K stated he comes out of his room				

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Facility Administrator

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Facility Name: Northern Maha	ska Specialty Care			Survey Dates: 10/20/21-12/9/21			
-	ss/City/State/Zip						
2401 Crestview Drive Oskaloosa, IA 52577		MW/DC					
Rule or		u		Fine Amount	Correction		
		e of Violation	Class		date		
Section							

	often in his boxers. There is not always a Nurse or staff at			
	the nurse's station. She stated she has to be within 15 to			
	20 feet of the nurse's station to hear the alarm. Staff K			
	stated she did not think the other residents are safe. Staff K			
	stated she closes doors to rooms because she knows he			
	could be on the move. Resident #16 had asked Staff K to			
	shut her door. Resident #16 told Staff K that one night she			
	had woke up and he (Resident #1) was standing over her			
	roommate. Staff K reported Resident #13 and Resident #16			
	were about the only 2 female residents that lived on the			
	200 hall that could say something to Resident #1.			
	On 10/26/21 at 2:15 p.m., Resident #13 stated that one			
	man tried to give her a kiss. She stated she had a pretty			
	good fist and knew right where she could have put it. She			
	was not afraid. She stated she had not problems after that.			
	On 10/26/21 at 12:22 p.m., Staff G, CNA stated she			
	switched to laundry a couple of weeks ago. She stated she			
	had seen inappropriate behavior between male and female			
	approximately 1 ½ months ago. Resident #1 and Resident #			
	13. She stated from her angle she was by the nurse's			
	station facing the 200 hall, she saw Resident #1 kiss			
	Resident #13 on the cheek. Staff G believed Resident #13			
	turned her head because she was uncomfortable and he			
	was trying to kiss her on the lips. The angle that Staff G was			
	at it looked like he was touching her shoulder but honestly			
	could not see. Resident #13 said "I need help" quite loudly.			
	Staff G could tell she was uncomfortable. Staff G stated			
	Resident #1 is tall about 6 feet and Resident #13 was sitting			
	down. An agency Nurse deescalated the situation and			
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Facility Administrator

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Numb #5492	er:			Date: Decem	ber 27, 2019	
Facility Name: Northern Maha	ska Specialty Care			Survey Dates: 10/20/21-12/9/21		
Facility Addres	ss/City/State/Zip					
2401 Crestviev		MW/DC	-			
Oskaloosa, IA	52577					
Rule or		μ		Fine Amount	Correction	
Code	Natur	e of Violation	Class		date	
Section						

took Resident #1 to his room. Staff G talked to Resident #13		
about it. Resident #13 said he tried to kiss her and she		
said no. Staff G said Resident #13 was kind of exasperated,		
kind of irritated. Resident #13 wanted to stay in the		
dining room area as she was visiting with another resident.		
Staff G could not tell if Resident #1 was touching		
Resident #13's breast or shoulder. Staff G told 2 Nurses and		
all of the aides what had happened as Resident #1 was		
mobile and she thought they should all keep an eye on him.		
On 10/26/21 at 2:50 p.m., Resident #14 stated		
approximately a month prior she had woke up in the		
middle of the night once and an older man was in her		
room. It kind of spooked her. She turned on her call light		
but couldn't get it to work. She stated he opened her		
bathroom door and started to unbutton her sweater. She		
stated Resident #1 will kiss her hand when they pass in the		
hallway just like a gentleman would. She stated		
approximately two weeks prior he had come into her room.		
He didn't come in very far. She stated it took her a while to		
get him out of her room.		
On 10/27/21 at 10:23 a.m., Staff J stated Resident #1 was		
on a 1:1 on that day. She did not know why resident was		
inappropriate or what he had done. She had not signed a		
clipboard. She had worked 5 days the week prior and had		
not signed the clipboard (15 minute checks). She stated if		
she is up by the nurse's station she can hear the door		
alarm. She stated if staff are in a room she doubted they		
, could hear the alarm.		

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Citation Numb #5492	per:			Date Dece	: ember 27, 2019
Facility Name: Northern Mahaska Specialty Care Facility Address/City/State/Zip 2401 Crestview Drive Oskaloosa, IA 52577		 	Survey - 10/20/21		
Rule or Code Section	Natur	Nature of Violation		Fine Amour	t Correction date
	On 10/27/21 at 10:37 a.m	n., clarified with Resident #15 that			

On 10/27/21 at 10:37 a.m., clarified with Resident #15 that			
resident did actually show her his genitalia. She said yes.			
She said she would worry about Resident #1 trying to touch			
other residents who may be handicapped or not have			
their mind. Resident #15 stated they wouldn't or might not			
be able to stop him. She stated she could tell him to stop.			
She repeated that she still feels uncomfortable around him.			
On 10/27/21 at 12:52 p.m., a female resident who resided			
on the 200 hall stated that when she first got to the facility			
a man tried coming in her room. She did not know his			
name. She stated she just shut her door. She stated it			
hadn't happened again in months.			
On 10/27/21 at 12:55 p.m., When asked if she felt residents			
are able to voice if they felt unsafe, Resident #14 stated			
there were a couple of residents that can't speak up. She			
named one resident then stated that her roommate would			
speak up for the resident she had named. Resident #14			
stated Resident #2 had encouraged Resident #1. She stated			
one time Resident #2 stopped at Resident #1's door and			
Resident #1 waved Resident #2 in. Resident #2 went in and			
Resident #1 grabbed her hand and kissed it, then she thinks			
he kissed her on the lips. Resident #14 was on a phone			
call and couldn't get up to kind of distract Resident #2. As			
soon as Resident #14 got off the phone she made a			
beeline to the nearest aide and told her. Resident #14			
stated that she looked after Resident #2 to make sure			
nothing inappropriate happens to her by Resident #1.			
I HOUTINE INAUDIOUNALE NAUDENS LO HEL DV RESIDENT #1.	1	1	

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Facility Administrator

Date

Citation Numb #5492	er:			Date: Deceml	ber 27, 2019	
Facility Name: Northern Maha	ska Specialty Care			Survey Dates: 10/20/21-12/9/21		
Facility Address/City/State/Zip 2401 Crestview Drive			10/20/21			
Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date	

On 10/27/21 at 1:10 p.m., Resident #16 stated a couple of		
nights ago someone was in her room standing by her		
roommate's bed. She lifted her head up so they knew she		
was watching and they walked out right away. She did not		
think that was okay. It was scary and she didn't like it. She		
stated she made sure they knew she was in there when he		
was standing over her roommate. Resident #16 stated that		
a couple of weeks prior someone came into her room 3		
times and even used her bathroom.		
On 10/28/21 at 10:15 a.m., Resident #13 stated she did not		
want a man kissing her or touching her whether he is confused or not.		
On 10/28/21 at 9:52 a.m., Staff A, CNA, stated that a		
husband got involved when Resident #1 had made		
advances. She identified the husband as Resident #19's		
husband. Staff #1 stated she knew something happened		
but didn't' see it herself. She said Resident #1 had made		
some kind of advance on her and her husband stopped it.		
On 10/28/21 at 2:35 p.m., Resident # 19's husband stated		
the only incident that they had was one of the residents		
came in to his wife's room and kissed her. Resident #19's		
husband stated he did not file a formal complaint. He met with administration at that time and told them that he did		
not want the male resident going down the same hall		
where his wife was living. They moved his wife right away		
per his insistence. He did not want her living on that same		
hall. I demanded they move her that same day. He stated		

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Facility Administrator

Citation Number: #5492					ate: ecemt	ber 27, 2019
Facility Name: Northern Mahaska Specialty Care Facility Address/City/State/Zip			Survey Dates: 			
2401 Crestvie Oskaloosa, IA		MW/DC				
Rule or Code Section	Natur	e of Violation	Class	Fine Amo	ount	Correction date
	facility did move her away On 10/28/21, Staff B, Mai Nursing Home Administra and said they needed an a out about the need for th He went up town and got alarm that was a sensor n concern regarding it being was pretty surefooted and a wheelchair. The doorma shut it off. Staff B stated t over the mat so it failed to #1 was a big guy and had stated he was asked to ge an alarm above the door alarm sounds when some in the doorway. It does no someone turns it off. The the call light system/boar heard by the staff at the t other way staff would kno On 11/2/21at 4:35 p.m., V felt if resident had not be was doing, Resident #17 s horrible. An observation on 11/2/2	ntenance Supervisor, stated the tor (NHA), had approached him alarm for Resident #1. He found e alarm through word of mouth. the alarm. They did start with an hat to the floor. Staff B had g a trip hazard but Resident #1 d his roommate at the time was in at would ring until someone would hat Resident #1 would step to alarm staff. Staff B said Resident a rather large stride. Staff B et something different. He placed on 9/20/21. Staff B stated the one passes underneath the alarm ot continue to sound until alarm does not alert staff through d. He stated if the alarm is not ime it is set off then there is no				

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	haska Specialty Care		Survey	Dates:	
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Rule or Code Section	Natur	e of Violation	Class	Fine Amou	nt Correction date
	room. The CNA stated that residents moved into the the room together over the On 11/2/21 at 4:40 p.m., felt if resident had not be was doing, Resident #15 s worse. She would have fe 11/10/21 at 10:38 a.m., R was aware of the incident were going to keep a closs The following correspond DON: On 11/22/21 at 12;49 P.M Residents # 2, #13, #15 ar On 11/22/21 at 4:32 p.m. have 15 minute checks fo than Resident #1 and Ress Nurse Manager stated state nurse who was no longer	When asked how she would have een confused and knew what he stated that would have been effective worse. Resident #22's daughter stated she t. Facility had alerted her and er eye out. Rences are from emails with the A., Request for consents on nd #17. , The DON responded they did not r any other incidents (other ident #2). She stated Staff R, aff interviews were done by a with the facility and that Staff R ation the nurse had gotten she			

consents on Resident #2, #13, #15, and #17. On 11/30/21 at 8:25 p.m., the DON responded that they had not found the consents. The Social Worker resigned with only 1 week notice and they have several stacks of papers that she had not had time to look through. The DON

On 11/30/21 at 3:19 p.m., a request was sent again for

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Facility Name: Northern Mahaska Specialty Care			Survey Dates: 10/20/21-12/9/21		
Facility Address/City/State/Zip			10/20/21-12/9/21		
2401 Crestviev		MW/DC	-		
Oskaloosa, IA	52577				
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wrote she would make it a priority in the morning.		
On 12/1/21 at 9:13 a.m., the DON wrote she visited with		
the QA team that morning and they all said there were no		
consents for the requested residents.		
On 12/1/21 at 9:26 a.m., the DON wrote that she found		
consents and attached them to the email. (1 consent out of		
the 3 consents the DON sent was for Resident #2. The other		
2 consents were for a male and female that were not in		
the survey sample.)		
On 12/1/21 at 9:45 a.m., a request was sent to the DON		
requesting a consent for Resident #13 as it was written per		
her documentation that a consent was done.		
On 12/1/21 at 12:03 p.m., the DON responded she would		
have staff double check in Resident #13's old files that had		
not been scanned in.		
On 12/1/21 at 3:43 p.m., the DON wrote Staff S, Nurse		
Manager, said they would just have the Social Worker do		
them on anyone who had previously shown interest in		
relations.		
On 12/1/21 at 4:45 p.m., a response to the DON answered		
that a review of the consents for the survey purpose would		
have needed to be done on the consent from the time of		
the incident. A request was sent asking if she had any		
information on the other 2 residents that were not in the		
sample for whom she had sent consents.		
On 12/1/21 at 8:03 p.m., the DON responded that she did		
not know anything about the 2 other residents and their		
consents. The DON wrote that Staff S informed her they		
tried to do consents on anyone that showed any interest in		
each other. The DON wrote that chances were it was 2		
residents that staff felt were getting close and wanted to		

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2401 Crestviev	v Drive					
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On 12/2/21 at 7:59 a.m., A request was sent to the DON asking for Incident Reports from 12/22/21 for Resident #1, from 7/15/21 for Resident #2, and from 3/15/21 for the 2 residents that were not in the sample. A date was requested for one of Resident #1's consent forms as it was not dated. On 12/2/21 at 3:38 p.m., the DON replied that she looked through the Incident Reports and did not find any for the residents and dates requested on 12/2/21 at 7:59 a.m. The DON also wrote she looked through the down files and did not find any consents for Resident #18 and Resident #22.		
 A Dependent Adult Abuse Protocols manual dated 11/2019, documented that: * All residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. * Residents must not be subjected to abuse by anyone including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. * Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. 		

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* Abuse includes verbal abuse, sexual abuse, physical		
abuse, and mental abuse including abuse facilitated or		
enabled through the use of technology.		
* Sexual abuse is non-consensual sexual contact of any type		
with a resident. Sexual abuse includes, but is not		
limited to:		
a. unwanted intimate touching of any kind especially of		
breasts or perineal area;		
b. All types of sexual assault or battery, such as rape,		
sodomy, and coerced nudity;		
c. Forced observation of masturbation and/or pornography;		
and		
d. taking sexually explicit photographs and/or audio/video		
recordings of a resident(s) and maintaining and/or		
distributing them.		
* Sexual contact is generally nonconsensual if the resident		
either:		
a. appears to want the contact to occur, but lacks the		
cognitive ability to consent; or		
b. does not want the contact to occur.		
*Resident to Resident sexual harassment, sexual coercion,		
or sexual assault is also considered 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 a resident		
unable to communicate physical harm, pain or mental		
anguish, in the absence of evidence to the contrary.		
The facility was notified of the immediate jeopardy and		
given the IJ template on October 27, 2021 at 1:00 pm. The		
immediate jeopardy was abated on October 28, 2021 after		
the facility provided education to staff on abuse		
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Citation Numb	er:			Date:	
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Facility Name:			Survey I	Dates:	
Northern Maha	aska Specialty Care				
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prevention and reporting. At the time of exit,	he scope and	
severity had been lowered to an E after verific		
staff's implementation of the abatement plan.		
FACILITY RESPONSE:		
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Date