STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date: _____ The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints #105247-C, #105401-C and #105503-C conducted 07/11/2022 - 07/16/2022. Complaint #105247-C was substantiated. Complaint #105401-C was substantiated. Complaint #105503-C was not substantiated. See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 1	F 578		

(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on facility policy review, clinical record review, and interviews, the facility failed to protect residents' right to formulate an advance directive for 8 (Resident #23, Resident #8, Resident #50, Resident #38, Resident #21, Resident #17, Resident #64, and Resident #18) of 8 residents reviewed for advance directives. Specifically, the facility failed to ensure all 8 residents reviewed were provided with information regarding their right to formulate an advance directive. The facility identified a census of 64 current residents.

Findings include:

A review of the facility's policy titled, "Advance Directives," revised December 2016, revealed, "1. Upon admission, the resident will be provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 2	F 578		

with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 2. Written information will include a description of the facility's policies to implement advanced directives and applicable state law." The policy also indicated, "7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. 8. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. a. The resident will be given the option to accept or decline the assistance, and care will not be contingent on either decision. b. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance."

1. A review of an "Admission Record" revealed the facility admitted Resident #23 on 10/07/2021.

A review of the quarterly Minimum Data Set (MDS), dated 06/23/2022, revealed Resident #23 had modified independence in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS), indicating the resident had some difficulty with new situations.

A review of a care plan, dated as initiated on 03/23/2022, revealed a focus related to the resident's advanced directive/code status. The goal was for the advance directives to be followed per resident/family request. The planned intervention was to honor the resident's wishes.

A review of Resident #23's electronic health record (EHR) on 07/12/2022 at 9:55 AM revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 3	F 578		

no documented evidence the resident had an advance directive on file, nor evidence the facility provided the option to formulate one.

During an interview on 07/12/2022 at 10:20 AM, the Interim Administrator (IADM) stated the resident's advance directive should be in the resident's EHR under the miscellaneous tab. The IADM was advised there were no advance directives available for review in Resident #23's EHR and was asked for a copy of the resident's advance directive.

During an interview on 07/13/2022 at 1:03 PM, the IADM provided a copy of the resident's code status. The IADM stated he did not know the difference between an advance directive and code status.

During an interview on 07/13/2022 at 3:31 PM, the IADM stated the Social Service Director (SSD) was responsible for completing the advance directive upon admission. The IADM stated if a resident had an advance directive in place, a copy was placed in their medical record. If the resident did not have one, the SSD went over the option to formulate one, and that document was located in the admission packet. The IADM stated the facility did not currently have an SSD. A copy of Resident #23's admission agreement was requested but not received.

A review of the facility's admission packet revealed an "Admissions Agreement" which included a list of resident rights. The right to formulate an advance directive was not included on the list. However, if the resident already had one formulated, the instructions on the form indicated it was to be attached to the admission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

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F 578	Continued From page 4	F 578		

agreement.

During an interview on 07/16/2022 at 4:14 PM, the IADM and Administrator (ADM) stated that an advanced directive should be offered upon admission, and the SSD completing the admission packet should go over the option to formulate an advance directive. The ADM stated that due to not having an SSD, the facility was dispersing the duties among the department heads.

2. A review of an "Admission Record" revealed the facility admitted Resident #8 on 03/17/2022.

A review of the quarterly MDS assessment, dated 06/23/2022, revealed the resident had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.

A review of Resident #8's care plan, dated as initiated on 3/18/2022, revealed the resident had an advanced directive/code status care plan with a goal for advance directives to be followed per resident/family request. The planned intervention was to honor the resident's wishes.

A review of Resident #8's EHR on 07/12/2022 at 10:48 AM revealed no documented evidence the resident had an advance directive on file, nor evidence the facility provided the option to formulate one.

During an interview on 07/12/2022 at 12:00 PM, the IADM was asked for a copy of the resident's advance directive.

During an interview on 07/13/2022 at 1:03 PM, the IADM provided a copy of the resident's code

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 5	F 578		

status. The IADM stated he did not know the difference between an advance directive and code status.

During an interview on 07/13/2022 at 3:31 PM, the IADM stated the Social Service Director (SSD) was responsible for completing the advance directive upon admission. The IADM stated if a resident had an advance directive in place, a copy was placed in their medical record. If the resident did not have one, the SSD went over the option to formulate one, and that document was located in the admission packet. The IADM stated the facility did not currently have an SSD. A copy of Resident #8's admission agreement was requested but not received.

A review of the facility's admission packet revealed an "Admissions Agreement" which included a list of resident rights. The right to formulate an advance directive was not included on the list. However, if the resident already had one formulated, the instructions on the form indicated it was to be attached to the admission agreement.

During an interview on 07/16/2022 at 4:14 PM, the IADM and Administrator (ADM) stated that an advanced directive should be offered upon admission, and the SSD completing the admission packet should go over the option to formulate an advance directive. The ADM stated that due to not having an SSD, the facility was dispersing the duties among the department heads.

3. A review of an "Admission Record" revealed the facility admitted Resident #38 on 05/04/2019.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 6	F 578		

A review of the quarterly MDS assessment, dated 05/12/2022, revealed the resident had a BIMS score of 9 out of 15, which indicated the resident was moderately cognitively impaired.

A record review of Resident #38's care plan, dated as initiated on 3/18/2022, revealed the resident had an advanced directive/code status care plan with a goal for advance directives to be followed per resident/family request. The planned interventions were to honor the resident's wishes, review the resident's choices quarterly and as needed, and to review the resident code status.

A review of Resident #38's EHR on 07/12/2022 at 12:32 PM revealed no documented evidence the resident had an advance directive on file, nor evidence the facility provided the option to formulate one.

During an interview on 07/13/2022 at 1:03 PM, the IADM provided a copy of the resident's code status. The IADM stated he did not know the difference between an advance directive and code status.

During an interview on 07/13/2022 at 3:31 PM, the IADM stated the Social Service Director (SSD) was responsible for completing the advance directive upon admission. The IADM stated if a resident had an advance directive in place, a copy was placed in their medical record. If the resident did not have one, the SSD went over the option to formulate one, and that document was located in the admission packet. The IADM stated the facility did not currently have an SSD. A copy of Resident #38's admission agreement was requested but not received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 7	F 578		

A review of the facility's admission packet revealed an "Admissions Agreement" which included a list of resident rights. The right to formulate an advance directive was not included on the list. However, if the resident already had one formulated, the instructions on the form indicated it was to be attached to the admission agreement.

During an interview on 07/16/2022 at 4:14 PM, the IADM and Administrator (ADM) stated that an advanced directive should be offered upon admission, and the SSD completing the admission packet should go over the option to formulate an advance directive. The ADM stated that due to not having an SSD, the facility was dispersing the duties among the department heads.

4. A review of an "Admission Record" revealed the facility admitted Resident #18 on 05/11/2022.

A review of the MDS assessment, dated 05/16/2022, revealed the resident had a BIMS score of 15.

A record review of Resident #18's care plan, initiated on 5/11/2022, revealed the resident had an advanced directive/code status care plan with a goal for advance directives to be followed per resident/family request. The planned intervention was to honor the resident's wishes.

A review of Resident #18's EHR on 07/12/2022 at 12:33 PM revealed no documented evidence the resident had an advance directive on file, nor evidence the facility provided the option to formulate one.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 8	F 578		

During an interview on 07/13/2022 at 1:03 PM, the IADM provided a copy of the resident's code status. The IADM stated he did not know the difference between an advance directive and code status.

During an interview on 07/13/2022 at 3:31 PM, the IADM stated the Social Service Director (SSD) was responsible for completing the advance directive upon admission. The IADM stated if a resident had an advance directive in place, a copy was placed in their medical record. If the resident did not have one, the SSD went over the option to formulate one, and that document was located in the admission packet. The IADM stated the facility did not currently have an SSD. A copy of Resident #18's admission agreement was requested but not received.

A review of the facility's admission packet revealed an "Admissions Agreement" which included a list of resident rights. The right to formulate an advance directive was not included on the list. However, if the resident already had one formulated, the instructions on the form indicated it was to be attached to the admission agreement.

During an interview on 07/16/2022 at 4:14 PM, the IADM and Administrator (ADM) stated that an advanced directive should be offered upon admission, and the SSD completing the admission packet should go over the option to formulate an advance directive. The ADM stated that due to not having an SSD, the facility was dispersing the duties among the department heads.

5. A review of the medical diagnosis list in the electronic medical record revealed Resident #64

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 9	F 578		

had diagnoses including encephalopathy, Parkinson's disease, heart disease, neuropathy, and gout.

A review of Resident #64's admission MDS assessment, dated 06/11/2022, revealed the resident had a BIMS score of 10, indicating the resident was moderately cognitively impaired.

A review of the care plan, dated 06/05/2022, revealed Resident #64 was care planned for advanced directives/code status. The goal was for the resident's advance directives to be followed per resident/family request. The planned intervention was to honor the resident's wishes.

A review of Resident #64's EHR revealed no documented evidence the resident had an advance directive, nor that the facility provided information regarding the resident's right to formulate one.

During an interview on 07/12/2022 at 10:55 AM, the surveyor requested a copy of advanced directive information for Resident #64 from the IADM. No information was provided.

During an interview on 07/13/2022 at 2:15 PM, the IADM revealed the SSD as responsible for assisting with advance directives on admission. He stated if the resident had an advance directive, it would be in the resident's medical record.

During an interview on 07/16/2022 at 10:06 AM, Interim Director of Nursing (IDON) B stated advance directive information should be obtained on admission. She stated the SSD used to obtain advance directive information; however, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 10	F 578		

facility had been without a SSD for about five months. She stated the facility obtained information regarding residents' code status (full code or do not resuscitate [DNR]) and stated a physician had to sign a DNR order. IDON B stated she was unsure about the difference between advanced directives and a DNR. She further stated she was unsure who was currently obtaining the information from residents but indicated the documents should be scanned into the medical record.

6. A review of an "Admission Record" revealed Resident #50 had diagnoses which included congestive heart failure, schizoaffective disorder, spinal fusion, and bipolar disorder.

A review of an annual MDS assessment dated 06/01/2022 revealed no assessment of the resident's cognitive status.

A review of a care plan dated 08/26/2021 revealed Resident #50 was care planned for advanced directives/code status. The goal was for the advanced directives to be followed per resident/family request. The planned intervention was to honor the resident's wishes.

A review of Resident #50's EHR revealed no documented evidence the resident had an advance directive, nor evidence the facility had provided information to the resident/responsible party regarding the right to formulate an advance directive.

7. A review of Resident #21's "Admission Record" revealed the resident had diagnoses that included chronic respiratory failure, dysphagia, and chronic obstructive pulmonary disease.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 11	F 578		

A review of an admission MDS assessment, dated 05/11/2022, revealed Resident #21 had a BIMS score of 15.

A review of a care plan, dated 04/15/2022, revealed Resident #21 was care planned for advanced directives/code status. The goal was for the advanced directives to be followed per resident/family request. The planned intervention was to honor the resident's wishes.

Review of Resident #21's EHR revealed no documented evidence the resident had an advance directive, nor evidence the facility had provided information to the resident on the right to formulate an advance directive.

8. Review of Resident #17's 'Admission Record" revealed the resident had diagnoses that included hip fracture, anemia, end stage renal disease, and muscle wasting and atrophy.

A review of the admission MDS assessment, dated 05/12/2022, revealed the resident had a BIMS score of 13, indicating intact cognition.

A review of a care plan, dated 05/06/2022, revealed Resident #17 was care planned for advanced directives/code status. The goal was for advanced directives to be followed per resident/family request. The planned intervention was to honor the resident's wishes.

A review of Resident #17's EHR revealed no documented evidence the facility had provided the resident with the opportunity to formulate an advance directive.

During an interview on 07/15/2022 at 10:04 AM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 12	F 578		

the MDS Coordinator revealed the SSD was responsible for getting advance directive information on admission to the facility; however, the facility had not had a SSD for approximately five months. She stated a staff member from another building came to the facility twice a week to help with the SSD's duties. She stated the facility had hired social workers in the past, but they had not worked out.

During an interview on 07/15/2022 at 10:10 AM, IDON B revealed the opportunity to formulate an advance directive should be offered by social services upon admission. She stated the facility had not had a SSD for a couple of months, and the IADM was doing admission paperwork. According to the IDON, advance directive information was offered with the admission paperwork.

On 07/15/2022 at 10:46 AM, during an interview with the Administrator, he stated advance directives were offered upon admission. He stated whoever did the admission, the Social Worker or nurse, should offer assistance with formulating an advance directive. He stated the facility did not have a Social Worker and was unsure how long the facility had been without one. When asked for documentation regarding advanced directives for Residents #17, #50, and #21, he stated the corporate nurse was checking to see whether the information could be located.

On 07/15/2022 at 11:51 AM, during an interview with IADM, he stated he could not provide documentation that advance directives had been offered to Residents #17, #50, and #21. He stated if a resident was not admitted with an advance directive, the staff person who admitted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 13 the resident should offer assistance with formulating one, and it should be scanned into the resident's medical record.	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 14	F 582		

60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on document review, interviews, record review, and facility policy review, the facility failed to provide written beneficiary notices for 2 (Residents #23 and #51) of three residents reviewed for beneficiary notification. The Administrator identified 18 residents who discharged from Medicare Part A with benefits remaining. The facility identified a census of 64 current residents.

Findings include:

A review of a facility policy titled, "Medicare Advance Beneficiary Notice," dated April 2021, revealed, "Residents are informed in advance when changes will occur to their bills. If the admissions coordinator or business office manager believes (upon admission or during the resident's stay) that Medicare (Part A of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

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F 582	Continued From page 15	F 582		

Fee-for-Service Medicare Program) will not pay for an otherwise covered skilled service(s), the resident (or representative) is notified in writing why the services(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s). The facility issues the Skilled Nursing Facility Advanced Beneficiary Notice (CMS form 10055) to the resident prior to providing care that Medicare usually covers but may not pay for because the care is considered 'not medically reasonable and necessary,' or 'custodial.' The resident (or representative) may choose to continue receiving the skilled services that may not be covered and assume financial responsibility. If the resident's Medicare Part A benefits are terminating for coverage reasons, the admissions coordinator or business office manager issues the Notice of Medicare Non-Coverage (CMS form 10123) to the resident at least two calendar days before Medicare covered services end (for coverage reasons). The Notice of Medicare Non-Coverage informs the resident of the pending termination of coverage and of his/her right to an expedited review of service determination. The Notice of Medicare Non-Coverage is not indicated when the resident's Medicare covered days are exhausted: nor is it used to notify the resident of potential liability for payment."

1. A review of an "Admission Record" revealed the facility admitted Resident #23 on 10/07/2021 and readmitted the resident on 03/23/2022 with diagnoses that included chronic obstructive pulmonary disease, orthopedic aftercare, and acute pain due to trauma.

A review of a quarterly Minimum Data Set (MDS) assessment dated 06/23/2022 revealed Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 16	F 582		

#23's most recent reentry to the facility was on 05/04/2022. According to the MDS, the resident's most recent Medicare covered stay started on 05/04/2022 and ended on 05/20/2022.

Review of the "Beneficiary Notice - Resident Discharged within the Last Six Months" list provided by the facility revealed Resident #23 discharged from Medicaid Part A services with benefits remaining on 05/20/2022 and remained in the facility.

A review of "Progress Notes," dated 05/18/2022 at 2:38 PM, revealed the facility notified a family member of the last covered day of therapy for the resident. The note revealed the facility recommended Hospice services; however, there was no evidence the facility provided a Notice of Medicare Non-Coverage to the resident or to the resident's family.

2. A review of Resident #51's significant change MDS assessment of 06/01/2022 revealed the resident had diagnoses that included fractures and other multiple traumas, anemia, atrial fibrillation, coronary artery disease, and diabetes. According to the MDS, the resident reentered the facility on 03/18/2022. The resident's Medicare-covered stay start date was 03/18/2022 and the end date was 05/18/2022.

Review of the "Beneficiary Notice - Resident Discharged within the Last Six Months" list provided by the facility revealed Resident #51 was discharged from services with benefits remaining on 05/18/2022 and remained in the facility. There was no evidence the facility provided a Notice of Medicare Non-Coverage to the resident or to the resident's family.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 17	F 582		

During an interview on 07/16/2022 at 1:49 PM, Resident #51's family member stated the facility did not provide written notice of Medicaid Part A services being stopped. He/she stated Resident #51 was at the end of therapy when the facility provided verbal notice.

On 07/14/2022 at 9:54 AM, during an interview with the Administrator, she stated the facility could not locate beneficiary notices for two of the three residents selected for beneficiary notice review. She stated the MDS Coordinator and the Assistant Director of Nursing (ADON) had been asked about the forms, and that she attempted to contact the former Administrator to locate the forms, but had been unable to locate them.

On 07/15/2022 at 10:52 AM, during an interview with the Administrator, she stated staff were unable to find Medicare Non-Coverage letters for Residents #23 and #51..

On 07/16/2022 at 10:16 AM, during an interview with the Interim Director of Nursing (IDON) B, she stated Beneficiary Notices were required to notify a resident when they were coming off skilled therapy. She stated the resident must be notified at least 48 hours in advance or sooner if the staff knew in advance. IDON B stated the MDS Coordinator oversaw getting that paperwork to residents.

During an interview with the Interim Administrator on 07/16/2022 at 4:22 PM, he revealed the Social Service Director (SSD) and the MDS Coordinator generally ensured beneficiary notices were provided. He stated he had no idea why the beneficiary notices were not provided for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

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F 582	Continued From page 18 Residents #23 and #51. He stated the documents should be scanned into the resident's chart when they were completed.	F 582		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 19	F 623		

allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

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F 623	Continued From page 20	F 623		

advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on facility policy review, clinical record review, and interviews, the facility failed to notify the office of the state long-term Ombudsman of a transfer/discharge for 1 (Resident #21) of two sampled residents reviewed for transfer/discharge notification. The facility identified a census of 64 current residents.

Findings include:

A facility policy titled, "Transfer or Discharge Notice," dated March 2021, revealed, "A copy of the notice is sent to the office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 21	F 623		

A review of Resident #21's "Admission Record" revealed the resident had diagnoses that included chronic obstructive pulmonary disease (COPD), chronic atrial fibrillation, and chronic respiratory failure.

A review of an admission Minimum Data Set (MDS) assessment dated 05/11/2022 revealed Resident #21 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS revealed the resident's admission date was 04/14/2022 and the reentry date was 04/28/2022.

A review of a "Progress Note," dated 04/23/2022 at 4:35 PM, revealed the resident transferred to the hospital for respiratory concerns. The resident returned to the facility on 04/28/2022. Review of Resident #21's medical record revealed no evidence the state long-term care Ombudsman's office was notified that the resident was transferred to the hospital.

On 07/15/2022 at 9:20 AM, during an interview with the Ombudsman, she stated the facility had not been notifying the Ombudsman's office when residents were transferred or discharged. She stated the facility should be notifying the agency at least monthly.

During an interview on 07/16/2022 at 10:47 AM, the Interim Director of Nursing (IDON) B, she stated if a resident was sent to the hospital, the physician, family, and DON should be notified. She stated Social Services notified the ombudsman every thirty days; however, the facility currently was without a Social Services employee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 22 On 07/16/2022 at 4:22 PM, during an interview with the Interim Administrator, he stated when a resident went to the hospital, the responsible party, physician, DON, and Administrator should be notified. He stated a report should also be sent to the Ombudsman at the end of each month. He stated when he came to the facility, the Ombudsman had not been notified of transfers/discharges for the month of May. He stated the Social Services Director oversaw sending hospitalization/discharge notices to the Ombudsman, but these duties had been split up to other staff members since the facility did not have a Social Services Director currently.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on facility policy review, clinical record review, and resident and staff interviews, the facility failed to ensure a staff completed an accurate comprehensive assessment for 1 (Resident #61) of 11 sampled residents who were reviewed for assessments. The facility failed to accurately assess Resident #61's dental status on the admission Minimum Data Set (MDS) assessment, which resulted in a delay in identifying and addressing dental issues in need of attention. The facility identified a census of 64 current residents. Findings include:	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 23	F 641		

A review of the facility policy titled, "Comprehensive Assessments and the Care Delivery Process Policy," dated 2001, revealed, "Comprehensive assessments, care planning and the care delivery process involve collecting and analyzing information." The policy also indicated, "Assess the individual, gather relevant information from multiple sources, including: observation, physical assessment, resident and family interview."

A review of the "Admission Record" revealed the facility admitted Resident #61 on 06/11/2022 with diagnoses that included morbid obesity and dysphagia.

Review of a "NSG [Nursing]: Admission/Readmission Evaluation" form, dated 06/12/2022, revealed Resident #61 was alert and oriented to person, place, time, and situation. The evaluation indicated the resident's upper and lower teeth were in good condition.

Review of a "Dietary Note," dated 06/13/2022, revealed the Registered Dietitian (RD) performed a remote nutritional assessment. The RD indicated that the resident's upper and lower teeth were in good condition and they had no chewing or swallowing difficulties, based on the documented admission evaluation completed by nursing.

A review of an admission MDS assessment dated 06/18/2022 revealed Resident #61 scored 14 on a Brief Interview for Mental Status (BIMS) test, which indicated intact memory and cognition. The MDS indicated the resident had no obvious or likely cavities or broken natural teeth.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 24	F 641		

Review of a "Progress Note," dated 06/27/2022 (approximately two weeks after admission), revealed the resident complained of difficulty chewing meat due to dentition. The physical exam revealed poor dentition.

During an interview on 07/11/2022 at 12:23 PM, Resident #61 stated there were issues with his/her teeth. The resident stated the bottom teeth were mostly removed or broken, with only a couple of teeth still in place. Resident #61 stated at least two of the teeth had broken and the roots were still in the gum. In a follow-up interview on 07/13/2022 at 1:01 PM, the resident stated s/he told staff about the condition of the teeth when admitted to the facility. The resident stated s/he was experiencing pain and was now on antibiotics.

Review of a "Progress Note," dated 07/11/2022 by the resident's provider, revealed the chief complaint/reason for visit was a swollen, painful, lower right gum. The resident's level of pain was described as five on a scale of zero to ten. The resident complained of achy, constant pain to the right gum/jaw/face area with associated swelling. The resident had pain with eating. The provider indicated the resident had a tooth broken off at the jawline. The physical exam indicated the resident had poor dentition and was mostly edentulous (without teeth). The remaining teeth were in poor condition/cracked. The right lower gum had inflammation and was tender to palpation. The provider indicated there was a possible abscess forming under the incisor area. The assessment and plan indicated a cracked tooth with early cellulitis versus abscess. The provider ordered Amoxicillin (an antibiotic) 500 milligrams three times daily for 10 days and a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 25	F 641		

dental referral.

During an interview on 07/16/2022 at 10:06 AM, Interim Director of Nursing (IDON) B stated the expectation for assessment of dental status at admission would be to look at the resident's teeth, gums, under the tongue, count the teeth, check for dentures and odor, and make note of any broken or missing teeth. The IDON B stated the resident would not be assessed to have good teeth if they had missing and broken teeth.

During a phone interview on 07/16/2022 at 1:29 PM, the MDS Coordinator stated that Resident #61 had never complained to him about problems with his/her teeth or gums. The MDS Coordinator stated the assessment was completed by a traveling staff member from a sister facility, and first MDS assessment was based on the initial nursing assessment.

During an interview on 07/16/2022 at 3:30 PM, Staff Y, Registered Nurse (RN), stated the resident had an abscess on the right gum and an order was received for antibiotic treatment a few days ago. Staff Y stated she put the order in the system for a dental referral and looked in the resident's mouth. The other side (left side) of the resident's mouth showed a tooth with decay with yellow at the base. She stated she did not agree with the admission assessment that indicated the resident's teeth were in good condition. Staff Y also stated the resident should have been referred to a dentist upon admission, based on the condition of their teeth.

On 07/16/2022 at 4:56 PM, the Administrator and Interim Administrator were interviewed. Both stated the expectation that dental assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 26 would be done soon after arrival and they would expect that the resident would be asked if s/he wore dentures. The resident's mouth should be opened so the staff could see the teeth. They stated if an accurate assessment had been completed, Resident #61 should have been referred to a dentist.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 27	F 656		

(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on facility policy review, clinical record review, and resident and staff interviews, the failed to develop a comprehensive care plan that addressed dental care needs for 1 (Resident #61) of 11 sampled residents reviewed for care plans. The facility failed to accurately assess the resident's dental status, which resulted in failure to identify dental problems in need of care and failure to address the necessary care on the comprehensive care plan. The facility identified a census of 64 current residents.

Findings include:

Review of a facility policy titled, "Comprehensive Assessments and the Care Delivery Process Policy," revised December 2016, revealed, "Comprehensive assessments, care planning and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions. Assessment and information collection includes (WHAT, WHERE and WHEN?). The objective of the information collection (assessment) phase is to obtain,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

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F 656	Continued From page 28	F 656		

organize, and subsequently analyze information about a patient. a. Assess the individual. (1) Gather relevant information from multiple sources, including: (a) Observation; (b) Physical assessment." The policy also indicated the following:
"b. Define conditions and problems that are causing, or could cause, other problems."
"d. Identify care goals and specific objectives of individual treatments."
"e. Make decisions about care and treatment."

A review of the "Admission Record" revealed the facility admitted Resident #61 on 06/11/2022 with diagnoses that included morbid obesity and dysphagia.

Review of a "NSG [Nursing]: Admission/Readmission Evaluation" form, dated 06/12/2022, revealed Resident #61 was alert and oriented to person, place, time, and situation. The evaluation indicated the resident's upper and lower teeth were in good condition.

Review of a "Dietary Note," dated 06/13/2022, revealed the Registered Dietitian (RD) performed a remote nutritional assessment. The RD indicated that the resident's upper and lower teeth were in good condition and they had no chewing or swallowing difficulties, based on the documented admission evaluation completed by nursing.

A review of an admission Minimum Data Set (MDS) assessment dated 06/18/2022 revealed Resident #61 scored 14 on a Brief Interview for Mental Status (BIMS) test, which indicated intact memory and cognition. The MDS indicated the resident had no obvious or likely cavities or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 29 broken natural teeth. Review of a "Progress Note," dated 06/27/2022 (approximately two weeks after admission), revealed the resident complained of difficulty chewing meat due to dentition. The physical exam revealed poor dentition. Review of a care plan, dated as revised on 06/13/2022, revealed the resident had a diet order for a regular, mechanical soft diet and was at nutritional risk related to dementia, diabetes mellitus, and dysphagia (difficulty swallowing). Interventions included having the dietitian to review the resident's diet routinely and referring the resident to speech therapy if indicated. The care plan did not address the resident's poor dentition or dental care needs. During an interview on 07/11/2022 at 12:23 PM, Resident #61 stated there were issues with his/her teeth. The resident stated the bottom teeth were mostly removed or broken, with only a couple of teeth still in place. Resident #61 further stated at least two of the teeth had broken and the roots were still in the gum.. During a phone interview on 07/16/2022 at 1:29 PM, the MDS Coordinator stated that Resident #61 had never complained to him about problems with his/her teeth or gums. The MDS Coordinator stated the initial assessment was completed by a traveling staff member from a sister facility, and the first MDS was based on the initial nursing assessment. The MDS Coordinator stated if the MDS had identified the issue, it would have triggered the care plan.	F 656		
F 657 SS=D	Care Plan Timing and Revision	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 30 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on facility policy review, clinical record review, and staff interviews, the facility failed to evaluate and revise the comprehensive care plan related to falls for 1 (Resident #23) of 2 sampled residents reviewed for accidents. Specifically, the facility failed to ensure appropriate fall-prevention interventions were initiated after the resident had numerous falls. The facility identified a census of	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 31	F 657		

64 current residents.

Findings included:

A review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered," revised December 2016, revealed, "The comprehensive, person-centered care plan will: g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems." Further review of the policy revealed, "10. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process." The policy also indicated, "11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making."

Review of an "Admission Record" revealed the facility admitted Resident #23 with diagnoses that included encounter for other orthopedic aftercare, difficulty in walking, lack of coordination, muscle weakness, history of falling, displaced intertrochanteric fracture of left femur, muscle wasting, and dizziness.

The quarterly Minimum Data Set (MDS) assessment, dated 06/23/2022, recorded Resident #23 had modified independence in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS), indicating the resident had some difficulty with new situations. The assessment recorded the resident required limited assistance of one person for transfers. According to the MDS, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 32	F 657		

resident had experienced one fall with no injury and one fall with injury since admission or prior assessment.

A review of Resident #23's care plan, dated as initiated on 03/23/2022, revealed the resident as at an increased risk for falls. The goal was for the resident to experience no injuries related to falls. The planned interventions included:
a. Encourage the resident to use the call light for assistance.
b. Provide a safe environment without clutter.
c. Ensure the resident wears appropriate footwear.
d. Monitor the resident for signs and symptoms that may warrant a change in condition.
e. Place non-skid strips in front of the recliner.

Further review of the care plan revealed the resident fell without injury on 06/02/2022 during a self-transfer and had a fall with a laceration to the back of the head on 06/05/2022. The goal was for the resident to resume usual activities without further incident. The planned interventions included:
a. Assess the resident's neurological status.
b. Continue the resident's at-risk plan.
c. Monitor the laceration with staples on the back of the head.
d. Monitor/document/report as needed for 72 hours any signs and symptoms of bruising, changes in mental status, new onset of confusion, sleepiness, inability to maintain posture, and agitation.
e. Physical therapy to evaluate and treat as needed.
f. Walker within reach just in case the resident decides to self-transfer again and a sign on the walker to remind the resident to use it when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 33	F 657		

transferring.

A review of an "Un-witnessed" incident report, dated 04/15/2022 at 6:15 AM, revealed Resident #23 was found sitting in front of his/her recliner, which was in the upright position. The resident had raised the recliner up and slid out onto the floor. The resident stated s/he must have been playing with the remote. The intervention for this fall was to place non-skid strips in front of the recliner.

A review of an "Un-witnessed" incident report, dated 04/19/2022 at 1:00 AM, revealed Resident #23 was found lying in front of his/her recliner. There were no interventions listed for this fall.

A review of an "Un-witnessed" incident report, dated 04/23/2022 at 3:45 AM, revealed Resident #23 had a fall in his/her bedroom; found approximately 4 feet from the recliner. The resident stated s/he was getting up and walked a few steps and fell. The resident was reminded to use his/her call light for assistance.

A review of an "Un-witnessed" incident report, dated 06/02/2022 at 8:15 AM, revealed Resident #23 was found lying on his/her right side, facing the front door. The resident's walker was not in reach and the wheelchair was parked against the wall. The resident stated he/she hit his/her head, but there were no injuries noted. Staff reminded the resident to use the call light and to have his/her walker within reach.

A review of an "Un-witnessed" incident report, dated 06/05/2022 at 4:30 AM, revealed Resident #23 found lying on the floor beside his/her bed. The resident stated s/he was just getting up to go

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 34	F 657		

to the bathroom and slipped. The resident sustained a laceration to the back of the head that measured approximately 1.5 inches long and transferred to the hospital. No interventions were listed for this fall.

A review of an "Incident, Accident, Unusual Occurrence" form, dated 06/05/2022 at 7:30 AM, revealed the resident returned to the facility with staples to the laceration on the back of the head.

A review of an "Un-witnessed" incident report, dated 07/04/2022 at 2:30 PM, revealed Resident #23 was found lying on the floor in front of his/her chair. The resident stated he/she accidentally kept pressing the 'up' button on the chair and the chair raised, causing the resident to fall to the floor. Staff educated the resident on the safety risks associated with the chair controller.

A review of an "Un-witnessed" incident report, dated 07/11/2022 at 9:30 AM, revealed Resident #23 was found lying on his/her left side in front of the recliner, which was in the upright position. There was a large pool of blood on the floor under the resident's head. The resident sustained a laceration to his/her forehead. The resident stated he/she raised the recliner up and was dumped out of it. The resident stated that his/her nose hit the floor. The intervention listed on the form instructed the facility staff members to change the recliner from electric to manual.

Review of a "Nurse's Note," dated 07/12/2022 at 3:50 PM, revealed the resident transferred to the hospital due to complaints of neck pain. Further review of the note revealed the resident had bilateral bruising to the eyes and a hematoma to the right lower eye and mid-forehead.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 35	F 657		

During an interview on 07/13/2022 at 9:58 AM, Interim Director of Nursing (IDON) B, stated the facility should try to figure out how to prevent the resident from falling and put an intervention in place to prevent future falls. The IDON stated she was unaware if the facility had completed a root cause analysis to identify why the resident was falling.

During an interview on 07/13/2022 at 2:37 PM, the Director of Clinical Operations (DCO), previously a nurse practitioner for the facility, stated the resident had a weak gait when he/she admitted. The DCO stated she was unaware of any interventions in place for the resident besides physical and occupational therapy, which the resident had started when admitted. The DCO stated that as a nurse practitioner, she reviewed residents' medications and complete laboratory work if the resident had multiple falls but was unsure if this was completed for Resident #23. The DCO stated the MDS Coordinator should update the care plan to include interventions related to falls. The DCO stated the resident's physician should take part in the root cause analysis to identify the cause of the resident's falls.

During an interview on 07/13/2022 at 3:54 PM, IDON A stated the DON was responsible for updating the resident's care plan after each fall to include interventions to prevent further falls.

During an interview on 07/13/2022 at 4:09 PM, Staff D, Agency Registered Nurse (RN), stated the RN on shift or the management team were responsible for updating the resident's care plan. Staff D stated the resident had experienced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 36	F 657		

several falls as of 07/04/2022, and on that day, the resident had lifted the recliner up and slipped out onto the floor. Staff D stated he did not complete a risk management form, which would notify other staff of the incident, because IDON A was supposed to complete it. Staff D stated interventions for Resident #23 included to ensure the call light in reach, to keep the bed in low position, perform routine two-hour checks, and to educate the resident on not pushing the remote on the recliner and not to transfer him/herself to the bed.

During an interview on 07/16/2022 at 10:05 AM, IDON B stated she was just appointed the IDON as of 07/15/2022, due to not having any other RNs in the facility. The IDON stated the nurse on duty could make changes to the care plan, but the MDS Coordinator was responsible for updating the care plan.

During an interview on 07/16/2022 at 1:29 PM, the MDS Coordinator stated the corporate office had contracted MDS Coordinators who had been completing the MDS Coordinator's duties, because she had to work as a floor nurse due to the facility being short-staffed. The MDS Coordinator stated that anyone on the nurse management team could update the resident's care plan or the nurse who witnessed an incident could update it. She stated if the incident happened while she was not at the facility, the nurse should update the care plan. The MDS Coordinator stated that in the end, it is the nurse management team that ensures it is updated, based on the risk management or anything that has happened. The falls should have been the DON updating the care plan, based on the risk management reports. The MDS Coordinator did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 37 not know why it was not updated. During an interview on 07/16/2022 at 4:14 PM, the Interim Administrator (IADM) and the Administrator (ADM) were interviewed together due to the ADM only being at the facility a week. The IADM stated the MDS Coordinator was responsible for updating the care plan, but the charge nurse had the ability to update it as well.	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up	F 661		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 38	F 661		

care and any post-discharge medical and non-medical services.
This REQUIREMENT is not met as evidenced by:
Based on facility policy review, clinical record review and resident and staff interviews, the facility failed to ensure a written discharge summary and information form was completed for 1 (Resident #71) of 1 resident reviewed for discharge. The facility identified a census of 64 current residents.

Findings include:

A review of the facility's policy titled, "Discharge Summary and Plan," revised December 2016, revealed, "When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment." Further review revealed, "2. The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident."

A review of the facility's policy titled, "Discharging a Resident without a Physician's Approval," revised October 2012, revealed, "3. If the resident or representative (sponsor) insists upon being discharged without the approval of the Attending Physician, the resident and/or representative (sponsor) must sign a Release of Responsibility form. Should either party refuse to sign the release, such refusal must be documented in the resident's medical record and witnessed by two staff members."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 39	F 661		

The "Admission Record" recorded the facility admitted Resident #71 on 03/25/2022.

A review of the admission Minimum Data Set (MDS) assessment, dated 03/31/2022, revealed Resident #71 scored 11 on a Brief Interview for Mental Status (BIMS), which indicated the resident experienced moderate cognitive and memory impairment.

A review of Resident #71's care plan, dated as initiated on 03/25/2022, revealed the resident had a transitional care plan with a goal to transition to the community. A planned intervention documented the resident would transition home with goals met and when clinically ready.

Review of a discharge-return not anticipated MDS assessment, dated 04/22/2022, revealed an unplanned discharge to the community on 04/22/2022.

Review of a "Social Services Note," dated 04/22/2022 revealed the facility requested a wellness check be performed by the police department since the resident left the facility against medical advice (AMA) the previous day.

A review of Resident #71's electronic health record (EHR) on 07/14/2022 at 11:29 AM revealed no evidence that staff completed a discharge summary for the resident.

During an interview on 07/14/2022 at 4:02 PM, the Regional Director of Clinical Services (RDCS) stated she was unable to locate a discharge summary, or any information related to the resident's discharge. At this time, the surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 40	F 661		

requested an AMA form for the resident.

During an interview on 07/15/2022 at 12:09 PM, Interim Director of Nursing (IDON) B stated Resident #71 was supposed to come off skilled nursing, and the therapy department recommended the resident to transition to long-term care. However, the resident's family took the resident home AMA. IDON B stated she spoke with therapy and, due to the resident's cognition, they recommended the resident be transferred to long-term care. IDON B stated the nurse on duty should have completed an AMA form, and the Social Service Director (SSD) would follow up with the resident after discharging from the facility. IDON B stated the nurse should have made a note about the resident's medications being returned to the pharmacy and that belongings went with the resident. IDON B stated the nurse should go over all current medications and other teaching as necessary.

During a phone interview on 07/15/2022 at 1:10 PM, Resident #71 stated s/he was living at home by him/herself and had a nurse and two aides (provided by the Veterans Affairs [VA])who came in to assist during the week. Resident #71 stated he/she could not afford the cost of the nursing home and did not want to sell their house because the resident wanted the house to go to family members. The resident stated the facility called after discharge and stated the resident was welcome to come back to the facility, but the resident could not afford it.

During an interview on 07/15/2022 at 2:33 PM, the MDS Coordinator stated Resident #71 plateaued in therapy and could not afford to stay for long-term care. The MDS Coordinator stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 41	F 661		

the resident's family member took the resident home. The MDS Coordinator stated the SSD had a meeting with the family member and the resident and advised them on the facility's recommendation to transfer to long-term care. The family member stated he/she was taking the resident home and then just packed up and left. The MDS Coordinator stated they should have signed an AMA form, depending on cognition. The MDS stated the facility did not do a discharge summary, because they did not go over any information with the resident, such as medications or treatments. The resident's medications went back to the pharmacy and not with the resident.

During an interview on 07/15/2022 at 10:05 AM, IDON B stated discharge planning should start upon admission, and the SSD was responsible for the discharge paperwork. However, the facility did not currently have an SSD.

On 07/16/2022 at 4:14 PM, the Interim Administrator (IADM) and the Administrator (ADM) were interviewed together due to the ADM being at the facility a week. The IADM stated the facility policy was to have the resident sign an AMA form. However, many times the resident refuses and just walks out the door. The IADM stated the nurse on duty should put documentation in the electronic health record (EHR) and include the reason for the discharge. If the nurse did not know what to do, they should contact the DON. The documentation should 'paint a picture of why they left AMA and do a DC summary as much as possible. The physician needed to be notified. The IADM further stated that nursing or the SSD should meet with the resident to discuss concerns with the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 42 before leaving AMA to ensure a safer discharge. As of 07/16/2022 at 5:33 PM, the facility had not provided an AMA form for Resident #71.	F 661		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews, document review, and facility policy review, the facility failed to investigate to determine the causative factors of falls to facilitate development of effective interventions to prevent further falls and minimize the risk of fall-related injuries for 1 (Resident #23) of 2 sampled residents reviewed for accidents, which resulted in a laceration to the head, bilateral bruising to the eyes, a hematoma to the right lower eye and mid-forehead, and neck pain resulting from a fall for Resident #23. Findings included: A review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered," revised December 2016, revealed, "The comprehensive, person-centered care plan will: g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems."	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 43	F 689		

Further review of the policy revealed, "10. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process." The policy also indicated, "11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making."

A review of the facility's policy titled, "Falls - Clinical Protocol," revised March 2018, revealed, "5. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the event, etc. [et cetera]." Further review of the policy revealed, "Cause Identification 1. For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall." Further review under, "Treatment/Management" revealed, "1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. 2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment and nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation." Further review under "Monitoring and Follow-Up" revealed, "1. The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. 2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 44	F 689		

The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling." Additionally, the policy indicated, "4. If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and also reconsider the current interventions."

Review of an "Admission Record" revealed the facility admitted Resident #23 with diagnoses that included encounter for other orthopedic aftercare, difficulty in walking, lack of coordination, muscle weakness, history of falling, displaced intertrochanteric fracture of left femur, muscle wasting, and dizziness.

A review of a quarterly Minimum Data Set (MDS), dated 06/23/2022, revealed Resident #23 had modified independence in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS), indicating the resident had some difficulty with new situations. Further review of the MDS revealed the resident required limited assistance of one person for transfers. According to the MDS, the resident had experienced one fall with no injury and one fall with injury since admission or prior assessment.

A review of Resident #23's care plan, dated as initiated on 03/23/2022, revealed the resident was at an increased risk for falls. The goal was for the resident to experience no injuries related to falls. The planned interventions included:
- Encourage the resident to use the call light for assistance.
- Provide a safe environment without clutter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 45	F 689		

- Ensure the resident wears appropriate footwear.
- Monitor the resident for signs and symptoms that may warrant a change in condition.
- Place non-skid strips in front of the recliner.

Further review of the care plan revealed the resident had a fall with no injury on 06/02/2022 during a self-transfer and a fall with a laceration to the back of the head on 06/05/2022. The goal was for the resident to resume usual activities without further incident. The planned interventions included:
- Assess the resident's neurological status.
- Continue the resident's at-risk plan.
- Monitor the laceration with staples on the back of the head.
- Monitor/document/report as needed for 72 hours any signs and symptoms of bruising, changes in mental status, new onset of confusion, sleepiness, inability to maintain posture, and agitation.
- Physical therapy to evaluate and treat as needed.
- Walker within reach just in case the resident decides to self-transfer again and a sign on the walker to remind the resident to use it when transferring.

A review of a "NSG [Nursing]: Fall Risk Evaluation," dated 03/23/2022, indicated the resident's total fall risk score was 12, with a score of 10 or above indicating the resident was at high risk for falls.

A review of a "Nurse's Note," dated 04/15/2022 at 6:15 AM, revealed Resident #23 had raised the recliner up and had fallen out of the recliner. Review of the "Un-witnessed" incident report, dated 04/15/2022 at 6:15 AM, revealed Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 46	F 689		

#23 was found sitting in front of his/her recliner, which was in the upright position. The resident had raised the recliner up and slid out onto the floor. The resident stated, "I must have been playing with the remote." The intervention for this fall was to place non-skid strips in front of the recliner.

A review of a "NSG: Fall Risk Evaluation," dated 04/15/2022, indicated the resident's total fall risk score was 12, with a total score of 10 or above indicating the resident was at high risk for falls.

A review of a "Incident, Accident, Unusual Occurrence Note," dated 04/19/2022 at 1:00 AM, revealed the resident was found lying on the floor in front of his/her recliner. A review of an "Un-witnessed" incident report, dated 04/19/2022 at 1:00 AM, revealed Resident #23 was found lying in front of his/her recliner. There were no interventions listed for this fall.

A review of a "NSG: Fall Risk Evaluation," dated 04/19/2022, indicated the resident's total fall risk score was 15, with a total score of 10 or above indicating the resident was at high risk for falls.

A review of an "SPN [Special Needs Plan]-Skilled Evaluation," dated 04/20/2022 at 3:33 PM, revealed the resident was on skilled nursing services and was working with therapy for strength training and rehabilitation services.

A review of a "Incident, Accident, Unusual Occurrence Note," dated 04/23/2022 at 3:45 AM, revealed the resident was found approximately 4 feet from his/her recliner. The resident was assisted back to the recliner and reminded to use the call light for assistance. A review of an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 47	F 689		

"Un-witnessed" incident report, dated 04/23/2022 at 3:45 AM, revealed Resident #23 had a fall in his/her bedroom and was found approximately 4 feet from the recliner. The resident stated, "I was getting up and walked a few steps and fell." The resident was reminded to use his/her call light for assistance.

A review of a "NSG: Fall Risk Evaluation," dated 04/23/2022, indicated the resident's total fall risk score was 10, with a total score of 10 or above indicating the resident was at high risk for falls.

A review of an "Un-witnessed" incident report, dated 06/02/2022 at 8:15 AM, revealed Resident #23 was found lying on his/her right side, facing the front door. The resident's walker was not in reach and the wheelchair was parked against the wall. The resident stated he/she hit his/her head, but there were no injuries noted. The resident was reminded to use the call light and to have his/her walker within reach. A review of an "Incident, Accident, Unusual Occurrence Note," dated 06/02/2022 at 2:35 PM, revealed Resident #23 was found lying on his/her right side, facing the front door. The resident's walker was not in reach and the resident's wheelchair was parked against the wall. The resident stated he/she hit his/her head, but there were no injuries noted. The resident was reminded to use the call light and to have his/her walker within reach.

A review of "NSG: Fall Risk Evaluation," dated 06/02/2022, indicated the resident's total fall risk score was 10, with a total score of 10 or above indicating the resident was at high risk for falls.

A review of "Un-witnessed" fall on 06/05/2022 at 4:30 AM revealed Resident #23 had a fall in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 48	F 689		

his/her bedroom and was found lying on the floor beside his/her bed. The resident stated, "I was just getting up to go to the bathroom and slipped." The resident sustained a laceration to the back of the head that measured approximately 1.5 inches long and was sent to the hospital. No interventions were listed for this fall.

A review of "NSG: Fall Risk Evaluation," dated 06/05/2022, indicated the resident's total fall risk score was 13, with a total score of 10 or above indicating the resident was at high risk for falls.

A review of an "Un-witnessed" incident report, dated 06/05/2022 at 4:30 AM, revealed Resident #23 was found lying on the floor beside his/her bed. The resident stated, "I was just getting up to go to the bathroom and slipped." The resident sustained a laceration to the back of the head that measured approximately 1.5 inches long and was sent to the emergency room. No interventions were listed for this fall.

A review of an "Incident, Accident, Unusual Occurrence" report revealed that on 06/05/2022 at 7:30 AM, the resident returned to the facility with staples to the laceration on the back of the resident's head.

A review of an "Un-witnessed" incident report, dated 07/04/2022 at 2:30 PM, revealed Resident #23 was found lying on the floor in front of his/her chair. The resident stated he/she accidentally kept pressing the "up" button on the chair and the chair raised, causing the resident to fall to the floor. The resident was educated on the safety risks associated with the chair controller.

There was no "NSG: Fall Risk Evaluation" for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 49	F 689		

07/04/2022 in the resident's electronic medical record (EHR).

There was no "Nurses Note" or "Incident, Accident, Unusual Occurrence" report related to the resident's fall on 07/04/2022.

A review of an "SPN-Focused Evaluation," dated 07/05/2022 at 10:45 AM, revealed the facility continued with neurological assessments of the resident after a fall.

During an observation on 07/11/2022 at 9:26 AM, two staff members came out into the hall and yelled down the hall that Resident #23 had fallen and there was blood.

A review of an "Un-witnessed" incident report, dated 07/11/2022 at 9:30 AM, revealed Resident #23 was found lying on his/her left side in front of the recliner, which was in the upright position. There was a large pool of blood on the floor under the resident's head. The resident sustained a laceration to his/her forehead. The resident stated he/she raised the recliner up and was dumped out of it. The resident stated that his/her nose hit the floor. The intervention listed on the form instructed the facility staff members to change the recliner from electric to manual. A review of an "Incident, Accident, Unusual Occurrence Note" indicated that on 07/11/2022 at 9:30 AM, the resident was found lying on his/her left side in front of his/her recliner and the recliner was in the upright position. There was a large pool of blood on the floor underneath the resident's head. The resident sustained a laceration to the forehead and had a bloody nose. The provider was notified via fax.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 50	F 689		

A review of a "NSG: Fall Risk Evaluation," dated 07/11/2022, indicated the resident's total fall risk score was 12, with a total score of 10 or above indicating the resident was at high risk for falls.

During an interview and observation on 07/11/2022 at 2:05 PM, Resident #23 was sitting in a manual recliner in his/her room with gauze wrapped around the resident's head. There was a quarter-sized circle of blood on the resident's forehead that was visible through the gauze. Resident #23 stated he/she was in the recliner with the remote control and had messed up the setting on the controller and "took a spill" from the recliner.

A review of a "Nurse's Note" revealed that on 07/12/2022 at 3:50 PM, the resident was sent to the hospital due to complaints of neck pain. Further review of the note revealed the resident had bilateral bruising to the eyes and a hematoma to the right lower eye and mid-forehead.

A review on 07/13/2022 at 8:15 AM of an "Incident by Incident Type" report indicated the resident had experienced six falls since admission, which included 04/15/2022, 04/19/2022, 04/23/2022, 06/02/2022, 06/05/2022, and 07/11/2022. There fall that occurred on 07/04/2022 was not listed.

During an interview on 07/13/2022 at 9:58 AM, Interim Director of Nursing (IDON) B, who at the time of the interview was a registered nurse working the floor and not the IDON, stated she was not aware of the resident having a fall on 07/04/2022. When asked about the neurological assessment she completed on 07/05/2022, which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 51	F 689		

indicated the resident had a fall, she requested to review the resident's electronic medical record (EMR). After the review, IDON B stated that the resident had the neurological assessments that started on 07/04/2022 after the resident had a fall. She stated she could not recall anything about the fall, only that it was in the afternoon on 07/04/2022 around the start of second shift (2:00 PM to 10:00 PM). She stated Staff D, Registered Nurse, initiated the neurological assessments. IDON B stated that she was unable to locate any information about the fall in the EMR or in the risk management section of the EMR, where falls were documented. IDON B stated that previous interventions for the resident's fall were grip strips in front of the recliner. After the fall on 07/11/2022, she requested that staff switch out the resident's recliner to a manual recliner. She stated she notified the nurse practitioner via fax and did not call the doctor. She stated the resident "was just bleeding from [their] forehead, no hematoma. I did not feel like it was an emergency issue." The IDON B stated she could only recall one other fall, which occurred in the middle of the night. The IDON B stated the facility should try to figure out how to prevent the resident from falling and put an intervention in place to prevent future falls. The IDON stated she was unaware if the facility completed a root cause analysis to identify why the resident was falling. IDON B stated that when a resident fell, the facility staff members were to complete an assessment, notify the family, notify the DON and/or management, and notify the physician. If the fall was unwitnessed, staff were to start neurological assessments and create an event in risk management in the EMR, which would include the assessment and what intervention was put into place. IDON B stated the Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 52	F 689		

Assurance (QA) team was supposed to review the falls in risk management, and she was not part of the QA team. The IDON stated that was how the facility previously addressed falls but was unsure how the facility addressed them currently.

During an interview on 07/13/2022 at 2:37 PM, the Director of Clinical Operations (DCO), who was a previous nurse practitioner for the facility, stated the resident had a weak gait when he/she was admitted. The DCO stated she was unaware of any interventions in place for the resident besides physical and occupational therapy, which the resident had started when he/she was admitted. The DCO stated that as a nurse practitioner, she reviewed the residents' medications and complete laboratory work if the resident had multiple falls but was unsure if this was completed for Resident #23. The DCO stated the Minimum Data Set (MDS) Coordinator should update the care plan to include interventions related to falls. The DCO stated the resident's physician should take part in the root cause analysis to identify the cause of the resident's falls.

During an interview on 07/13/2022 at 3:54 PM, Interim Director of Nursing (IDON) A stated the DON was responsible for updating the resident's care plan after each fall to include interventions to prevent further falls. IDON A stated that when a resident fell, staff were to assess the resident, and if the fall was unwitnessed, start neurological assessments and complete a risk management form, which would include an intervention. If the resident fell and hit his/her head, staff should call 911. IDON A stated, "It's very strange here" because the staff faxed the doctor when a resident fell instead of calling them. IDON A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 53	F 689		

stated she had been teaching staff to call instead of fax. IDON A stated she was present when the resident fell on 07/04/2022 and that Staff B was the nurse working with the resident. IDON A stated that she started the risk management form, and Staff B was supposed to complete it. IDON A stated she finished the form today (07/13/2022). IDON A stated for the fall on 07/04/2022, the resident was in his/her recliner and did not let go of the remote controller and it "sling shotted" the resident to the floor. IDON A stated the resident had a BIMS of 15, which indicated the resident was cognitively intact, and she educated the resident on the safety of the chair. IDON A stated she was not aware the resident had previous falls from the recliner.

During an interview on 07/13/2022 at 4:09 PM, Staff D, Agency Registered Nurse, stated the RN on shift or the management team were responsible for updating the resident's care plan. Staff D stated the resident had several falls as of 07/04/2022, and on that day, the resident had lifted the recliner up and slipped out onto the floor. Staff D stated he did not complete a risk management form, which would notify other staff of the incident, because IDON A was supposed to complete it. Staff D stated interventions for Resident #23 included to ensure the call light was in reach, keep the bed in low position, routine two-hour checks, and educate the resident on not pushing the remote on the recliner and not to transfer him/herself to the bed.

During an interview on 07/16/2022 at 10:05 AM, IDON B stated she was just appointed the IDON as of 07/15/2022 due to not having any other registered nurses in the facility. The IDON stated the nurse on duty could make changes to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 54	F 689		

care plan, but the MDS Coordinator was responsible for updating the care plan.

During an interview on 07/16/2022 at 1:29 PM, the MDS Coordinator stated that the corporate office had contracted MDS Coordinators who had been completing the MDS Coordinator's duties because she had to work as a floor nurse due to the facility being short-staffed. The MDS Coordinator stated that anyone on the nurse management team could update the resident's care plan, or the nurse who witnessed the incident could update it. She stated that if the incident happened while she was not at the facility, the nurse should update the care plan. She stated, "In the end, it is the nurse management team that ensure it is updated, based on the risk management or anything that's happened. Those falls should have been the DON [Director of Nursing] updating the care plan based on the risk management reports. I don't know why it wasn't updated."

During an interview on 07/16/2022 at 4:14 PM, the Interim Administrator (IADM) and the Administrator (ADM) were interviewed together due to the ADM only being at the facility a week. The IADM stated the MDS Coordinator was responsible for updating the care plan, but the charge nurse had the ability to update it as well. The IADM stated the facility should complete a root cause analysis of the resident's falls but did not believe there were any for this resident; otherwise, the IADM would have looked at how the falls occurred. The IADM stated he would have to complete a root cause analysis before he could state what interventions should have been put into place. The IADM stated the root-cause was discussed during the morning meetings and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 55 the interdisciplinary team (IDT) would determine the root cause. The IADM stated the fall on 07/04/2022 should have been documented in risk management. Then the DON would review the risk management information to ensure all information was completed, which included the neurological assessment, notification, and interventions. The IADM stated the DON had to sign off on the risk management form, then the IADM had to review it and sign off on it, then it was "locked" in the system.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on facility policy review, clinical record review, observations, and resident and staff interviews, the facility failed to ensure oxygen was provided to an oxygen-dependent resident as ordered by the physician for 1 (Resident #48) of 2 sampled residents reviewed for oxygen care. The Administrator identified 11 residents who required respiratory treatment and a census of 64 current residents. Findings include: Review of a facility policy titled, "Oxygen	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 56	F 695		

Administration," dated October 2010, revealed, "The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders for oxygen administration. Review the resident's care plan to assess for any special needs of the resident. Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: signs and symptoms of hypoxia (i.e. [such as], rapid breathing, rapid pulse rate, restlessness, confusion."

A review of an "Admission Record" revealed Resident #48 had diagnoses including multiple sclerosis and chronic obstructive pulmonary disease (COPD).

The quarterly Minimum Data Set (MDS) assessment dated the 05/30/2022 identified Resident #48 had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired memory and cognition. Resident #48 required assistance for transfers, bed mobility, and locomotion. Per the MDS, the resident received oxygen therapy within the last 14 days.

A review of an "Order Summary Report" revealed Resident #48 had an order dated 04/03/2021 for oxygen at two liters per minute via nasal cannula, continuously except for during meals and showers.

Review of a care plan, revised 04/13/2022, revealed Resident #48 had emphysema/COPD with a goal was for the resident to be free of signs and symptoms of respiratory infections. Interventions included providing oxygen at two liters via nasal cannula, continuously except for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 57	F 695		

meals and showers.

On 07/11/2022 at 3:42 PM, an observation and interview conducted with Resident #48 revealed the resident was not using oxygen. The resident stated he/she used oxygen all the time, but staff did not place it back on after the resident ate lunch. Resident #48 stated he/she was having a hard time breathing.

During an interview with Staff O, Certified Nursing Assistant (CNA), on 07/11/2022 at 3:45 PM, Staff O indicated Resident #48 was not oxygen dependent. Staff O stated Resident #48 only had to have oxygen on if he/she felt like he/she needed it.

During an observation and interview on 07/11/2022 at 3:47 PM, Staff P, Registered Nurse (RN), checked Resident #48's oxygen saturation, which measured 85% on room air (normal range is 95-100% for healthy people and 88-92% for someone with severe COPD). The resident's oxygen saturation fluctuated from 82% to 90% as Staff P checked it. Staff P stated she was not sure if the resident was oxygen-dependent. Staff P asked Resident #48 if she could apply the oxygen, and Resident #48 agreed. Staff P stated she reviewed the resident's orders, and the resident should have oxygen continuously, except at meals and during showers. Staff P stated staff should apply the resident's oxygen as ordered to keep the oxygen saturation up. She stated if Resident #48 did not have the oxygen in place, he/she could become hypoxic and confused and she that had not seen any signs of hypoxia or confusion with Resident #48.

During a follow-up interview on 07/11/2022 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 58	F 695		

3:55 PM, Staff O stated she verified with the nurse that Resident #48 should have oxygen continuously, except at meals and during showers.

During an observation and interview on 07/13/2022 at 10:36 AM, Resident #48 was not using oxygen. The oxygen tubing lay on the floor. The resident stated he/she took the oxygen off to eat breakfast and could not reach the oxygen to put it back on.

During an interview on 07/13/2022 at 11:02 AM, Staff Q, CNA stated she was unsure if Resident #48 could put his/her own oxygen back on. Staff Q stated she only applied Resident #48's oxygen at night, had not checked the resident's medical record and did not know if the resident was oxygen-dependent.

On 07/13/2022 at 11:06 AM, observation revealed Resident #48 in his/her room with the oxygen off.

During an interview on 07/14/2022 at 8:37 AM, the MDS Coordinator stated she thought Resident #48's oxygen was ordered as needed to keep the resident's oxygen saturation above 90 percent. She reviewed Resident #48's physician's orders and stated it had been changed and was required to be provided continuously, except for meals and showers. The MDS Coordinator stated Resident #48 could take the oxygen off but could not put it on. She stated Resident #48 did pull it off at times and staff put it back on during rounds.

An observation on 07/14/2022 at 2:52 PM, revealed Resident #48 sat in the dining area without oxygen and without eating.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 59 During an interview on 07/16/2022 at 10:12 AM, Interim Director of Nursing (IDON) B stated if the resident had physician orders for continuous oxygen, the oxygen should be in place. IDON B stated oxygen was to help the resident's oxygen saturation to stay above 90 percent. During an interview on 07/16/2022 at 4:47 PM, the Interim Administrator stated residents should have oxygen on per physician's orders. He stated it was facility staff's responsibility to educate residents if they took off their oxygen and they needed to reapply it. He stated oxygen was to keep oxygen saturation up and prevent negative outcomes. During an interview on 07/14/2022 at 12:33 PM, the Medical Director stated if Resident #48's oxygen was dropping, the resident should use oxygen continuously. She stated staff should follow the physician's orders and that Resident #48 could get hypoxic or have a COPD exacerbation and end up in the hospital.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on facility policy review, clinical record review, and staff interviews, the facility failed to ensure pre and post-dialysis assessments were consistently conducted and documented for 1	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 60	F 698		

(Resident #17) of 1 sampled resident reviewed for dialysis assessments. The Administrator identified two dialysis residents who resided in the facility and a census of 64 current residents.

Findings include:

Review of a facility policy titled, "End-Stage Renal Disease, Care of a Resident with," dated September 2010, revealed, "Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care."

A review of an "Admission Record" revealed the facility admitted Resident #17 on 05/06/2022 with a diagnosis of end stage renal disease (ESRD).

Review of an admission Minimum Data Set (MDS) assessment dated 05/12/2022 revealed the resident scored 13 on a Brief Interview for Mental Status (BIMS), indicating intact cognition. The assessment also documented Resident #17 required dialysis while living at the facility.

Review of a care plan, dated 05/06/2022, revealed the resident was to receive hemodialysis treatments related to ESRD every Monday, Wednesday, and Friday.

A review of "Dialysis Evaluation" forms, dated 05/11/2022 through 07/13/2022, revealed 56 opportunities for pre-dialysis and post-dialysis evaluations to be completed. Pre or post-dialysis evaluations were not completed during 18 of the 56 opportunities.

During an interview on 07/15/2022 at 2:04 PM, the MDS Coordinator stated Resident #17 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 61	F 698		

dialysis on Mondays, Wednesdays, and Fridays. She stated she completed the pre-dialysis and post-dialysis assessments on dialysis days. The MDS Coordinator stated these were completed to get a baseline of the resident's status before and after dialysis and she was unsure of why the assessments were not completed.

During an interview on 07/16/2022 at 1:31 PM, Staff N, Registered Nurse (RN), stated staff should complete pre-dialysis and post-dialysis assessments on the days the resident had dialysis. She reviewed Resident #17's chart and stated there were dialysis assessments not completed. Staff N stated she did not know why the assessments were not being completed consistently. On two of the missing dates, agency staff were working.

During an interview on 07/15/2022 at 2:20 PM, the MDS Coordinator stated Resident #17 had never missed a dialysis appointment.

During an interview on 07/16/2022 at 10:10 AM, Interim Director of Nursing (IDON) B stated staff should be completing a pre-dialysis and post-dialysis assessment. IDON B did not know why the pre-dialysis and post-dialysis assessments were not completed.

During an interview on 07/16/2022 at 4:55 PM, the Interim Administrator stated dialysis assessments should be completed before the resident left the facility and upon return. He was made aware of the missing assessments and stated Resident #17 usually went straight to therapy when he/she came back from dialysis, and staff may be missing those assessments because they did not see the resident right away.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 62 He stated staff should be completing those assessments.	F 698		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on facility policy/job description reviews, observations, interview, and document review, the facility failed to ensure a Registered Nurse (RN) served as the Director of Nursing (DON) on a full-time basis. The facility identified a census of 64 current residents. Findings included: A review of the facility's policy titled, "Staffing" revised October 2017, revealed, the "Facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and facility assessment." A review of the facility's "Care Initiatives Job	F 727		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 63	F 727		

Description" for the Director of Nursing position, revised May 2011, revealed, "Under general supervision of the Administrator, the Director of Nursing manages Nursing Department human and material resources, with responsibility and accountability for provision of quality nursing care and service to facility residents/families, compliance with applicable laws and regulations, and adherence to company policy/procedure and budgetary guidelines. Functions with extensive autonomy in daily nursing department operations; prior approval required for activities having significant budgetary or employee relations impact. Technical assistance, professional guidance and quality monitoring is provided by the Director of Nursing with added assistance from the assigned Nurse Consultant, Medical Director, Administrator, Vice President/Operations and other corporate staff also available as resources."

Observation during the recertification and complaint survey on 07/11/2022 through 07/16/2022, revealed Interim DON B worked as a direct care staff nurse, providing direct resident care, administering medications, and performing other floor nurse duties.

During an interview with Interim DON B on 07/16/2022 at 3:28 PM, she stated that since being appointed Interim DON, she still had to work as a staff nurse, providing resident care, passing medications, and other direct care tasks. She stated there was no time to do the things normally expected of a DON and it was the same for the last Interim DON.

An interview with the Interim Administrator on 07/16/2022 at 5:20 PM revealed it was not the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 64 desire of management for the DON to work as a staff nurse. However, he stated until the permanent DON began working in August 2022, the Interim DON had to be on the floor providing resident care due to the facility being short-staffed.	F 727		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to	F 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 65 exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on facility policy and document review, observations, and staff interviews, the facility failed to post the nurse staffing information on a daily basis, to include the facility name, the current date, the number and actual hours worked by staff, and the resident census. The facility identified a census of 64 current residents. Findings included: Review of the facility policy titled, "Staffing," dated 10/2017, revealed, "Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care." The policy did not address posting requirements. Observations at the nurses' station during the six-day survey from 07/11/2022 through 07/16/2022 revealed the "Daily Nurse Staffing" sheets stored in a plastic stand at the nurses' station. Review of the "Daily Nurse Staffing" on 07/11/2022 revealed the report contained the facility name, date, and census of 66. There were no staff names listed as working for any of the three shifts. When the survey team entered on 07/11/2022, the census was noted to be 64.	F 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 66	F 732		

Observations on 07/12/2022 revealed the previous day's report for 07/11/2022 still in the plastic holder, with no additional information.

A review of the "Daily Nurse Staffing" dated 07/13/2022, revealed for day shift the census was 65 and there were no staff listed on the sheet. The sheet indicated the actual hours worked on day shift were two hours for registered nurses (RN), one hour for licensed practical nurses (LPN), and five hours for certified nurse aides (CNA). The evening shift noted a census of 64 and had three hours of RN time, zero hours of LPN time, and four hours of CNA time. The night shift noted a census of 64 with one hour of RN time, zero hours of LPN time, and three hours of CNA time.

There was no updated report posted on 07/14/2022.

A review of the "Daily Nurse Staffing" sheet dated 07/15/2022 revealed the census was 65 and the day shift noted eight hours for RNs, eight hours for LPNs, and 48 hours for CNAs. There was no documentation for evening or night shift.

A review of the "Daily Nurse Staffing" sheet dated 07/16/2022 revealed the census was 62 and the sheet noted eight hours of RN time and 48 hours of CNA time. There was no further documentation on the 07/16/2022 report.

During an interview on 07/12/2022 at 8:05 AM, Interim Director of Nursing (DON) A stated the staff would be updating the form.

On 06/16/2022 at 3:28 PM, when asked who was responsible for completing the staffing forms

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 67 daily, Interim DON B stated 'just whoever.' During an interview on 7/16/2022 at 5:10 PM, the Scheduling Coordinator stated the staffing sheets were put out when the daily list of who was working was completed.	F 732		
F 745 SS=E	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, document review, and facility policy review, the facility failed to employ a social worker to meet social services needs for 10 residents (#71, #8, #17, #18, #21, #23, #38, #50, #64, and #68) of 10 sampled residents reviewed for social services needs. Specifically, the facility failed to ensure discharge planning was provided for 1 (Resident #71) of 1 sampled resident reviewed for discharge planning; failed to ensure residents were informed of their right to formulate advance directives for 8 residents (#8, #17, #18, #21, #23, #38, #50, and #64) of 8 residents reviewed for advance directives; failed to ensure the Ombudsman was notified of facility-initiated transfers/discharges for 1 (Resident #21) of 3 residents reviewed for Ombudsman notification and failed to ensure advanced beneficiary notices (ABNs) were provided for 2 residents (#23 and #51) of 3 sampled residents reviewed for beneficiary notices. The facility identified a census of 64 current residents.	F 745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 68	F 745		

Findings include:

Review of a facility policy titled, "Social Services," dated October 2010, revealed, "Our facility provides medically related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being. Policy Interpretation and Implementation. 1. The Director of Social Services is a qualified social worker and is responsible for: ... b. Consultation to allied professional health personnel regarding provisions for the social and emotional needs to the resident and family; ... d. An adequate record system for obtaining, recording and filing of social service data; 2. Medically related social services is provided to maintain or improve each resident's ability to control everyday physical needs (e.g. [for example] appropriate adaptive equipment for eating, ambulation, etc.) and mental and psychosocial needs (e.g., sense of identity, coping abilities, and sense of meaningfulness or purpose) ... 4. The social department is responsible for: a. Obtaining pertinent social data about person and family problems related to the resident's illness and care; ... c. Assisting in providing corrective action for the resident's needs by developing and maintaining individualized social services care plans; ... k. Working with individuals and groups in developing supportive services for residents according to their individual needs and interests; ... m. Participating in the planning of the resident's admission, return to home and community, or transfer to another facility by assessing the impact of these changes and making arrangements for social and emotional support."

1. A review of the facility's policy titled, "Discharge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 69	F 745		

Summary and Plan," revised December 2016, revealed, "When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment." Further review revealed, "2. The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident."

A review of the facility's policy titled, "Discharging a Resident without a Physician's Approval," revised October 2012, revealed, "3. If the resident or representative (sponsor) insists upon being discharged without the approval of the Attending Physician, the resident and/or representative (sponsor) must sign a Release of Responsibility form. Should either party refuse to sign the release, such refusal must be documented in the resident's medical record and witnessed by two staff members."

A review of the "Admission Record" revealed the facility admitted Resident #71 on 03/25/2022.

A review of the admission Minimum Data Set (MDS) assessment, dated 03/31/2022, revealed Resident #71 scored 11 on a Brief Interview for Mental Status (BIMS), which indicated the resident was moderately cognitively impaired.

A review of Resident #71's care plan, dated as initiated on 03/25/2022, revealed the resident had a transitional care plan with a goal to transition to the community. The planned intervention was that the resident would transition home with goals met

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 70	F 745		

and when clinically ready.

Review of a discharge-return not anticipated MDS assessment, dated 04/22/2022, revealed an unplanned discharge to the community was completed on 04/22/2022.

Review of a "Social Services Note," dated 04/22/2022 revealed the facility requested a wellness check be performed by the police department since the resident left the facility against medical advice (AMA) the previous day.

A review of Resident #71's electronic health record (EHR) on 07/14/2022 at 11:29 AM revealed no evidence a discharge summary was completed for the resident.

During an interview on 07/14/2022 at 4:02 PM, the Regional Director of Clinical Services (RDCS) stated she was unable to locate a discharge summary, or any information related to the resident's discharge. At this time an "Against Medical Advise (AMA) form" for the resident was requested.

During an interview on 07/15/2022 at 12:09 PM, Interim Director of Nursing (IDON) B stated the resident was supposed to come off skilled nursing, and the therapy department recommended the resident to transition to long-term care. However, the resident's family took the resident home AMA. She stated she spoke with therapy and, due to the resident's cognition, they recommended the resident be transferred to long-term care. IDON B stated the nurse on duty should have completed an AMA form, and the Social Service Director (SSD) would follow up with the resident after discharging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 71	F 745		

from the facility. IDON B stated the nurse should have made a note about the resident's medications being returned to the pharmacy and that the resident's belongings went with the resident. IDON B stated the nurse should go over all current medications and other teaching as necessary.

During a phone interview on 07/15/2022 at 1:10 PM, Resident #71 stated he/she was living at home by him/herself and had a nurse and two aides, which were provided by the Veterans Affairs (VA), who came in to assist him/her during the week. Resident #71 stated he/she could not afford the cost of the nursing home and did not want to sell his/her house because the resident wanted the house to go to family members. The resident stated the facility called after discharge and stated the resident was welcome to come back to the facility, but the resident could not afford it.

During an interview on 07/15/2022 at 2:33 PM, the MDS Coordinator stated the resident plateaued in therapy and could not afford to stay for long-term care. The MDS Coordinator stated the resident's family member took the resident home. The MDS stated the SSD had a meeting with the family member and the resident and advised them on the facility's recommendation to transfer to long-term care. The family member stated he/she was taking the resident home and then just packed up and left. The MDS Coordinator stated they should have signed an AMA form, depending on cognition. The MDS stated the facility did not do a discharge summary, because they did not go over any information with the resident, such as medications or treatments. The resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 72	F 745		

medications went back to the pharmacy and not with the resident.

During an interview on 07/15/2022 at 10:05 AM, IDON B stated discharge planning should start upon admission, and the SSD was responsible for the discharge paperwork. However, the facility did not currently have an SSD.

During an interview on 07/16/2022 at 4:14 PM, the Interim Administrator (IADM) and the Administrator (ADM) were interviewed together due to the ADM only being at the facility a week. The IADM stated the facility policy was to have the resident sign an AMA form. However, many times the resident refuses and just walks out the door. The IADM stated the nurse on duty should put documentation in the electronic health record (EHR) and include the reason for the discharge. If the nurse did not know what to do, they should contact the DON. The documentation should 'paint a picture of why they left AMA and do a DC summary as much as possible. The physician needs to be notified.' The IADM further stated that nursing or the SSD should meet with the resident to discuss concerns with the resident before leaving AMA to ensure a safer discharge.

The facility did not currently have a Social Services Director, so an interview was not completed.

As of 07/16/2022 at 5:33 PM, the survey team had not received an AMA form for Resident #71.

2. A review of the facility's policy titled, "Advance Directives," revised December 2016, revealed, "1. Upon admission, the resident will be provided with written information concerning the right to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 73	F 745		

refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 2. Written information will include a description of the facility's policies to implement advanced directives and applicable state law." The policy also indicated, "7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. 8. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. a. The resident will be given the option to accept or decline the assistance, and care will not be contingent on either decision. b. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance."

Review of the facility's admission packet revealed an "Admissions Agreement" which included a list of resident rights. The right to formulate an advance directive was not included on the list. However, if the resident already had one formulated, the instructions on the form indicated it was to be attached to the admission agreement.

2a. A review of an "Admission Record" revealed the facility admitted Resident #23 on 10/07/2021.

A review of the quarterly MDS assessment, dated 06/23/2022, revealed Resident #23 had modified independence in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS), indicating the resident had some difficulty with new situations.

A review of a care plan, dated as initiated on 03/23/2022, revealed a focus related to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 74	F 745		

resident's advanced directive/code status. The goal was for the advance directives to be followed per resident/family request. The planned intervention was to honor the resident's wishes.

A review of Resident #23's EHR on 07/12/2022 at 9:55 AM revealed no documented evidence the resident had an advance directive on file, nor evidence the facility provided the option to formulate one.

During an interview on 07/13/2022 at 3:31 PM, the IADM stated the SSD was responsible for completing the advance directive upon admission. The IADM stated if a resident had an advance directive in place, a copy was placed in their medical record. If the resident did not have one, the SSD went over the option to formulate one, and that document was located in the admission packet. The IADM stated the facility did not currently have an SSD. A copy of Resident #23's admission agreement was requested but not received.

During an interview on 07/16/2022 at 4:14 PM, the IADM and Administrator (ADM) stated that an advanced directive should be offered upon admission, and the SSD completing the admission packet should go over the option to formulate an advance directive. The ADM stated that due to not having an SSD, the facility was dispersing the duties among the department heads.

2b. A review of an "Admission Record" revealed the facility admitted Resident #8 on 03/17/2022.

The MDS assessment, dated 06/23/2022, recorded the resident had a BIMS score of 15 out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 75	F 745		

of 15, which indicated the resident was cognitively intact.

A review of Resident #8's care plan, dated as initiated on 3/18/2022, revealed the resident had an advanced directive/code status care plan with a goal for advance directives to be followed per resident/family request. The planned intervention was to honor the resident's wishes.

A review of Resident #8's EHR on 07/12/2022 at 10:48 AM revealed no documented evidence the resident had an advance directive on file, nor evidence the facility provided the option to formulate one.

During an interview on 07/13/2022 at 3:31 PM, the IADM stated the SSD was responsible for completing the advance directive upon admission. The IADM stated if a resident had an advance directive in place, a copy was placed in their medical record. If the resident did not have one, the SSD went over the option to formulate one, and that document was located in the admission packet. The IADM stated the facility did not currently have an SSD. A copy of Resident #8's admission agreement was requested but not received.

During an interview on 07/16/2022 at 4:14 PM, the IADM and Administrator (ADM) stated that an advanced directive should be offered upon admission, and the SSD completing the admission packet should go over the option to formulate an advance directive. The ADM stated that due to not having an SSD, the facility was dispersing the duties among the department heads.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 76	F 745		

2c. A review of an "Admission Record" revealed the facility admitted Resident #38 on 05/04/2019.

A review of the quarterly MDS assessment, dated 05/12/2022, revealed the resident had a BIMS score of 9 out of 15, which indicated the resident was moderately cognitively impaired.

A record review of Resident #38's care plan, dated as initiated on 3/18/2022, revealed the resident had an advanced directive/code status care plan with a goal for advance directives to be followed per resident/family request. The planned interventions were to honor the resident's wishes, review the resident's choices quarterly and as needed, and to review the resident code status.

A review of Resident #38's EHR on 07/12/2022 at 12:32 PM revealed no documented evidence the resident had an advance directive on file, nor evidence the facility provided the option to formulate one.

During an interview on 07/13/2022 at 1:03 PM, the IADM provided a copy of the resident's code status. The IADM stated he did not know the difference between an advance directive and code status.

During an interview on 07/13/2022 at 3:31 PM, the IADM stated the SSD was responsible for completing the advance directive upon admission. The IADM stated if a resident had an advance directive in place, a copy was placed in their medical record. If the resident did not have one, the SSD went over the option to formulate one, and that document was located in the admission packet. The IADM stated the facility did not currently have an SSD. A copy of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 77	F 745		

Resident #38's admission agreement was requested but not received.

During an interview on 07/16/2022 at 4:14 PM, the IADM and Administrator (ADM) stated that an advanced directive should be offered upon admission, and the SSD completing the admission packet should go over the option to formulate an advance directive. The ADM stated that due to not having an SSD, the facility was dispersing the duties among the department heads.

2d. A review of an "Admission Record" revealed the facility admitted Resident #18 on 05/11/2022.

A review of an admission MDS assessment, dated 05/16/2022, revealed the resident had a BIMS score of 15.

A record review of Resident #18's care plan, dated as initiated on 5/11/2022, revealed the resident had an advanced directive/code status care plan with a goal for advance directives to be followed per resident/family request. The planned intervention was to honor the resident's wishes.

A review of Resident #18's EHR on 07/12/2022 at 12:33 PM revealed no documented evidence the resident had an advance directive on file, nor evidence the facility provided the option to formulate one.

During an interview on 07/13/2022 at 3:31 PM, the IADM stated the SSD was responsible for completing the advance directive upon admission. The IADM stated if a resident had an advance directive in place, a copy was placed in their medical record. If the resident did not have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 78	F 745		

one, the SSD went over the option to formulate one, and that document was located in the admission packet. The IADM stated the facility did not currently have an SSD. A copy of Resident #18's admission agreement was requested but not received.

During an interview on 07/16/2022 at 4:14 PM, the IADM and ADM stated that an advanced directive should be offered upon admission, and the SSD completing the admission packet should go over the option to formulate an advance directive. The ADM stated that due to not having an SSD, the facility was dispersing the duties among the department heads.

2e. A review of the medical diagnosis list in the electronic medical record revealed Resident #64 had diagnoses including encephalopathy, Parkinson's disease, heart disease, neuropathy, and gout.

A review of Resident #64's admission MDS assessment, dated 06/11/2022, revealed the resident had a BIMS score of 10, indicating the resident was moderately cognitively impaired.

A review of the care plan, dated 06/05/2022, revealed Resident #64 was care planned for advanced directives/code status. The goal was for the resident's advance directives to be followed per resident/family request. The planned intervention was to honor the resident's wishes.

A review of Resident #64's medical record revealed no documented evidence the resident had an advance directive, nor that the facility provided information regarding the resident's right to formulate one.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 79	F 745		

During an interview on 07/12/2022 at 10:55 AM, the surveyor requested a copy of advanced directive information for Resident #64 from the IADM. No information was provided.

During an interview on 07/13/2022 at 2:15 PM, the IADM stated the SSD was responsible for assisting with advance directives on admission. He stated if the resident had an advance directive, it would be in the resident's medical record.

During an interview on 07/16/2022 at 10:06 AM, IDON B stated advance directive information should be obtained on admission. IDON B stated the SSD used to obtain advance directive information; however, the facility had been without a SSD for about five months and she was unsure who was currently obtaining the information from residents but indicated the documents should be scanned into the medical record.

2f. A review of an "Admission Record" revealed Resident #50 had diagnoses which included congestive heart failure, schizoaffective disorder, spinal fusion, and bipolar disorder.

A review of an annual MDS assessment dated 06/01/2022 revealed no assessment of the resident's cognitive status.

A review of a care plan dated 08/26/2021 revealed Resident #50 was care planned for advanced directives/code status. The goal was for the advanced directives to be followed per resident/family request. The planned intervention was to honor the resident's wishes.

A review of Resident #50's medical record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 80	F 745		

revealed no documented evidence the resident had an advance directive, nor evidence the facility had provided information to the resident/responsible party regarding the right to formulate an advance directive.

2g. A review of Resident #21's "Admission Record" revealed the resident had diagnoses that included chronic respiratory failure, dysphagia, and chronic obstructive pulmonary disease.

A review of an admission MDS assessment, dated 05/11/2022, revealed Resident #21 had a BIMS score of 15.

A review of a care plan, dated 04/15/2022, revealed Resident #21 was care planned for advanced directives/code status. The goal was for the advanced directives to be followed per resident/family request. The planned intervention was to honor the resident's wishes.

Review of Resident #21's medical record revealed no documented evidence the resident had an advance directive, nor evidence the facility had provided information to the resident on the right to formulate an advance directive.

2h. Review of Resident #17's 'Admission Record" revealed the resident had diagnoses that included hip fracture, anemia, end stage renal disease, and muscle wasting and atrophy.

A review of an admission MDS assessment dated 05/12/2022, revealed the resident had a BIMS score of 13, indicating intact cognition.

A review of a care plan, dated 05/06/2022, revealed Resident #17 was care planned for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 81	F 745		

advanced directives/code status. The goal was for advanced directives to be followed per resident/family request. The planned intervention was to honor the resident's wishes.

A review of Resident #17's medical record revealed no documented evidence the facility had provided the resident with the opportunity to formulate an advance directive.

During an interview on 07/15/2022 at 10:04 AM, the MDS Coordinator stated the SSD was responsible for getting advance directive information on admission to the facility; however, the facility had not had a SSD for approximately five months. She stated a staff member from another building came to the facility twice a week to help with the SSD's duties. She stated the facility had hired social workers in the past, but they had not worked out.

During an interview on 07/15/2022 at 10:10 AM, IDON B stated the opportunity to formulate an advance directive should be offered by social services upon admission. She stated the facility had not had a SSD for a couple of months, and the IADM was doing admission paperwork. According to the IDON, advance directive information was offered with the admission paperwork.

On 07/15/2022 at 10:46 AM, the ADM stated advance directives were offered upon admission. He stated whoever did the admission, the Social Worker or nurse, should offer assistance with formulating an advance directive. He stated the facility did not have a SSD and was unsure how long the facility had been without one. When asked for documentation regarding advanced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 82	F 745		

directives for Residents #17, #50, and #21, he stated the corporate nurse was checking to see whether the information could be located.

On 07/15/2022 at 11:51 AM, during an interview with IADM, he stated he could not provide documentation that advance directives had been offered to Residents #17, #50, and #21. He stated if a resident was not admitted with an advance directive, the staff person who admitted the resident should offer assistance with formulating one, and it should be scanned into the resident's medical record.

3. Resident #21 was admitted with diagnoses which included chronic obstructive pulmonary disease (COPD) and chronic respiratory failure.

A review of the 05/11/2022 admission MDS assessment for Resident #21 revealed the resident scored 15 on a BIMS test.

Review of a "Nurse's Note," dated 04/23/2022 at 4:35 PM, revealed the resident transferred to the hospital for respiratory concerns. Review of the medical record revealed no evidence the Ombudsman was notified of the transfer.

During an interview on 07/15/2022 at 9:20 AM, the Ombudsman stated the facility had not been notifying the Ombudsman's office when residents were transferred or discharged. She stated the facility should be notifying the agency monthly.

During an interview on 07/16/2022 at 10:47 AM, DON B stated if a resident was sent to the hospital, the physician, family, and DON should be notified. She stated the Ombudsman was notified by social services every thirty days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 83	F 745		

During an interview on 07/16/2022 at 4:22 PM, the IADM stated when a resident was sent to the hospital the responsible party, physician, DON, and ADM should be notified. He stated a report should be sent to the ombudsman at the end of each month. He stated when he came to the facility, the ombudsman was not notified for the month of May. He stated the SSD oversaw sending the statement of hospitalization/discharges to the Ombudsman, but these duties would be split up to other staff members since the facility did not currently have an SSD. He stated he sent May's report on 06/28/2022 and June's report on 07/13/2022.

4a. Review of an "Admission Record" revealed the facility admitted Resident #23 on 03/23/2022 and readmitted the resident on 05/04/2022 with diagnoses which included orthopedic aftercare and COPD.

A review of a quarterly MDS assessment dated 06/23/2022 revealed Resident #23 had a Medicare stay with a start date of 05/04/2022 and an end date 05/20/2022.

A review of the "Beneficiary Notice - Resident Discharged within the Last Six Months" revealed Resident #23 discharged from Medicare Part A services with benefits remaining on 05/20/2022.

4b. Review of an "Admission Record" revealed the facility admitted Resident #51 on 06/24/2020 with diagnoses which included dementia without behavioral disturbance, muscle wasting and atrophy, and contractures of both hands.

A review of a quarterly MDS assessment, dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 84	F 745		

06/01/2022, revealed the resident required extensive assistance with bed mobility, transfers, and toileting. The MDS indicated the resident had a Medicare stay with a start date of 03/18/2022 and an end date 05/18/2022.

A review of the "Beneficiary Notice - Resident Discharged Within the Last Six Months" revealed Resident #51 discharged from Medicare Part A services with benefits remaining on 05/18/2022.

During an interview on 07/14/2022 at 9:54 AM, the ADM stated the Beneficiary Notices were not located for two (Resident #23 and Resident #51) of the three residents selected for ABN review. She stated the MDS Coordinator and the Assistant Director of Nursing (ADON) had been asked about the ABNs, and that an attempt was made to contact the former Administrator to locate the forms, but the facility had been unable to locate them.

On 07/15/2022 at 10:52 AM, during an interview with the ADM, she stated further efforts to locate the ABNs had been unsuccessful.

On 07/16/2022 at 10:16 AM, during an interview with IDON B, she stated the purpose of the Beneficiary Notices was to notify the resident when they were coming off skilled therapy. She stated the resident must be notified at least 48 hours in advance, or sooner if the staff knew in advance. She stated Social Services and the MDS Coordinator were responsible for providing the Beneficiary Notices to the residents.

On 07/16/2022 at 1:49 PM, during an interview with Resident #51's family member, he/she stated the facility had not provided written notice of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 85 Medicare Part A services being stopped. He/she stated Resident #51 was at the end of therapy when the facility gave them verbal notice. On 07/16/2022 at 4:22 PM, during an interview with the IADM, he stated generally, Social Services and the MDS Coordinator took care of the Beneficiary Notices. He stated he had no idea why the Beneficiary Notices were not provided. Once the documents were received back from the family, the documents should be scanned into the resident's medical record. The medical records of Resident #23 and Resident #51 were reviewed for Beneficiary Notices, and none were found.	F 745		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on facility policy review, clinical record review, and staff interviews, the facility failed to ensure laboratory services were provided per physician's orders for 1 (Resident #8) of 5 residents selected for medication regimen review. The facility identified a census of 64 current residents. Findings include:	F 770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 86	F 770		

A review of a facility policy titled, "Lab and Diagnostic Test Results: Physician Role and Follow-Up," revised September 2017, indicated, "1. The facility shall use a systematic process for obtaining and reviewing lab and diagnostic test results and reporting results to physicians." Further review of the policy revealed, "17. Physicians or nurses should communicate any concerns about how test results have been handled or reported to the DON [Director of Nursing] and/or medical director."

A review of the "Admission Record" revealed the facility admitted Resident #8 on 03/17/2022 with diagnoses that included atherosclerotic heart disease (a condition where the arteries become narrowed and hardened due to buildup of fats in the artery wall), long term use of anticoagulants (blood thinners), presence of a cardiac pacemaker and prosthetic heart valve, and peripheral vascular disease (a blood circulation disorder that affects the supply of blood outside the heart and brain).

A review of the quarterly Minimum Data Set (MDS) assessment, dated 06/23/2022, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Further review of the MDS revealed the resident received a daily anticoagulant medication during the assessment period.

Review of Resident #8's care plan, initiated on 3/18/2022, revealed the resident took routine Coumadin due to atrial fibrillation with a goal to be free from discomfort or adverse reactions related to anticoagulant use. The planned interventions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 87	F 770		

were to monitor for side effects and perform labs as ordered.

A review of an "Order Summary Report" indicated the resident had a laboratory (lab) order for a PT/INR (prothrombin time/international normalized ratio, a blood clotting test) to be completed every Friday morning related to the diagnosis of atherosclerotic heart disease, with a start date of 04/15/2022. Further review of the report indicated the resident received Coumadin, a blood thinner, 3 milligrams one time per day on Monday, Tuesday, Wednesday, Thursday, Saturday, and Sunday, with a start date of 07/02/2022.

On 07/14/2022 at 10:02 AM, the PT/INR lab results were requested for the last three months. The following dates were received: 07/08/2022, 07/01/2022, 06/24/2022, 05/27/2022, 05/20/2022, 05/13/2022, 04/29/2022, and 04/22/2022. The following dates were missing: 06/17/2022, 06/10/2022, 06/03/2022, 05/06/2022, and 04/15/2022.

A review of the Lab Administration Record (LAR) for April 2022 indicated there was no PT/INR completed on Friday 04/08/2022 and Friday 04/22/2022.

A review of the LAR for May 2022 indicated there was no PT/INR completed on Friday 05/13/2022 and Friday 05/20/2022.

A review of the LAR for June 2022 indicated there was no PT/INR completed on Friday 06/03/2022, Friday 06/10/2022, and Friday 06/17/2022.

A review of the LAR for July 2022 indicated there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 88	F 770		

was no PT/INR completed on Friday 07/01/2022 and Friday 07/08/2022.

On 07/14/2022 at 11:31 AM, the missing lab orders for the dates listed above were requested from the Interim Administrator (IADM), Administrator (ADM), and Staff P, Nurse Manager.

On 07/14/2022 at 1:45 PM, Staff P stated she was unable to locate the labs for the specified dates.

On 07/16/2022 at 1:29 PM, the MDS Coordinator, who worked as a floor nurse, stated the facility had a lab technician from the local hospital who came to the facility every Friday to draw the lab orders that were due. The MDS Coordinator stated she did not know why Resident #8's labs were not completed on the missing dates. The MDS Coordinator stated she did not go through the resident's labs. The MDS Coordinator stated the resident could have refused the lab draw. The MDS Coordinator stated if the resident did refuse a lab draw, it should be documented in the resident's chart and put in the resident's care plan. The MDS Coordinator stated one of the nurse managers or the Director of Nursing (DON) was responsible for ensuring lab orders were being completed.

During an interview on 07/16/2022 at 1:52 PM, Interim Director of Nursing (IDON) B, who was a charge nurse until 07/14/2022, stated the local hospital came every Friday to complete lab orders, unless it was urgent, then facility staff completed the order. IDON B stated she did not think there was a process in place to ensure labs were being completed as ordered. The facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 89 used to have a routine lab order binder but had stopped utilizing a binder. IDON B stated she was unsure if anyone was monitoring to ensure labs were being completed. IDON B stated if the order was put in correctly, it should alert the nurse on duty in the Medication Administration Record (MAR), and it would flag that the lab needed to be completed. During an interview on 07/16/2022 at 4:14 PM, the IADM stated the DON was responsible for ensuring that lab orders were being completed. The IADM stated the facility had a process in place to go over lab orders during the daily morning clinical meeting. However, Resident #8's lab orders were missed because the facility had not been conducting the meeting due to nurse managers having to work as floor nurses. The IADM stated the IDON and IADM did not know the process for lab draws, either. The IADM stated that if the lab order flagged on the MAR, it should also flag the DON, and the DON should review those flags and address any issues during the morning meeting.	F 770		
F 791 SS=G	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 90 (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to provide dental services to meet the needs of 1 (Resident #61) of 1 sampled resident reviewed for dental needs. The facility admitted Resident #61 with missing and broken teeth and failed to accurately assess the resident's dental status and identify dental	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 91	F 791		

issues in need of attention, which resulted in a delay in treating the dental issues. The resident subsequently developed pain and an abscessed tooth requiring antibiotic treatment.

Findings included:

A review of the facility policy titled, "Dental Examination/Assessment Policy," dated 2001, revealed, "Resident shall be offered dental services as needed." The policy also indicated, "Upon conducting a dental examination, a resident needing dental services will be promptly referred to a dentist."

A review of an "Admission Record" revealed the facility admitted Resident #61 on 06/11/2022 with diagnoses that included morbid obesity and dysphagia.

Review of a, "NSG [Nursing]: Admission/Readmission Evaluation," dated 06/12/2022, revealed Resident #61 was alert and oriented to person, place, time, and situation. The evaluation indicated the resident's upper and lower teeth were in good condition.

Review of a "Dietary Note," dated 06/13/2022, revealed the Registered Dietitian (RD) performed a remote nutritional assessment. The RD indicated that the resident's upper and lower teeth were in good condition and that the resident had no chewing or swallowing difficulties, based on the documented admission evaluation that had been completed by nursing.

A review of an admission Minimum Data Set (MDS) dated 06/18/2022 revealed Resident #61 scored 14 on a Brief Interview for Mental Status

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 92	F 791		

(BIMS), which indicating the resident was cognitively intact. The MDS indicated the resident had no obvious or likely cavities or broken natural teeth.

Review of a "Progress Note," dated 06/27/2022 (approximately two weeks after admission), revealed the resident complained of difficulty chewing meat due to dentition. The physical exam revealed poor dentition.

During an interview on 07/11/2022 at 12:23 PM, Resident #61 stated there were issues with his/her teeth. The resident stated the bottom teeth were mostly removed or broken, with only a couple of teeth still in place. Resident #61 further stated at least two of the teeth had broken and the roots were still in the gum. In a follow-up interview on 07/13/2022 at 1:01 PM, the resident revealed he/she had told staff about the condition of the teeth when he/she was admitted to the facility. The resident stated he/she was experiencing pain and was now on antibiotics.

Review of a "Progress Note," dated 07/11/2022, revealed the chief complaint/reason for visit was a swollen, painful, lower right gum. The resident's level of pain was described as five on a scale of zero to ten. The resident complained of achy, constant pain to the right gum/jaw/face area with associated swelling. The resident had pain with eating. The provider indicated the resident had a tooth broken off at the jawline. The physical exam indicated the resident had poor dentition and was mostly adentulous (without teeth). The remaining teeth were in poor condition/cracked. The right lower gum had inflammation and was tender to palpation. The provider indicated there was a possible abscess forming under the incisor area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 93	F 791		

The assessment and plan indicated a cracked tooth with early cellulitis versus abscess. The provider ordered Amoxicillin 500 milligrams three times daily for ten days and a dental referral.

During an interview on 07/16/2022 at 10:06 AM, the Interim Director of Nursing (DON) revealed the expectation for assessment of dental status at admission would be to look at the teeth, gums, under the tongue, count the teeth, check for dentures and odor, and make note of any broken or missing teeth. The Interim DON stated the resident would not be assessed to have "good teeth" if there were missing and broken teeth. The Interim DON stated Resident #61 should have been referred to a dentist. The Interim DON further stated the facility was without a Social Services Director currently, and in the absence of a Social Worker, she was not sure who would be responsible for dental referrals.

During an interview on 07/16/2022 at 3:30 PM, Staff Y, Registered Nurse (RN), stated the resident had an abscess on the right gum and an order was received for antibiotic treatment a few days ago. She stated she put the order in the system for a dental referral and looked in the resident's mouth. She stated on the other side (left side) of the resident's mouth, there was a tooth with decay that was yellow at the base. She stated she did not agree with the admission assessment that indicated the resident's teeth were in good condition. She also stated the resident should have been referred to a dentist upon admission, based on the condition of the resident's teeth.

On 07/16/2022 at 4:56 PM, the Administrator and Interim Administrator were interviewed. It was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

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F 791	Continued From page 94 their expectation that the assessment would be done soon after arrival and they would expect that the resident would be asked if he/she wore dentures. The resident's mouth should be opened so the staff could see the teeth. They stated if an accurate assessment had been completed, Resident #61 should have been referred to a dentist.	F 791		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observations, staff interviews, and review of facility documentation, the facility failed to ensure food was stored and prepared properly and safely, kitchen equipment was maintained in clean condition, and staff kept their hair covered when	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 95	F 812		

in the kitchen area. Specifically, the facility failed to label and date food and discard outdated food in order to reduce the risk of food-borne illness; failed to cool leftover food properly to reduce the risk of food-borne illness failed to maintain the ice machine in clean condition; failed to ensure all staff entering the kitchen wore hair restraints; and failed to ensure dirty utensils were not placed in the handwashing sink. The facility identified a census of 64 current residents.

Findings include:

1. A review of the policy titled, "Personnel Health Standards and Conduct" from the Dietary Services Policy and Procedure Manual dated February 2016 revealed "hair will be properly covered by a hair restraint."

Observations on 07/11/2022 at 9:45 AM revealed the Administrator (ADM) walked into the kitchen with no hair restraint. She went to the dishwasher area to talk to staff. Further observations during the initial tour of the kitchen revealed Staff C, Maintenance Staff, was observed in the kitchen with no hair restraint.

On 07/14/2022 at 6:16 AM, Staff L, Certified Nursing Assistant (CNA), was observed going into the kitchen to get ice with no hair restraint.

On 07/14/2022 at 6:24 AM, Staff J was observed going into the kitchen with no hair restraint to get coffee for a resident.

During an interview on 07/11/2022 at 3:15 PM, the Interim Dietary Manager (IDM) stated anyone entering the kitchen needed to have a hairnet on before entering.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

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F 812	Continued From page 96	F 812		

During an interview on 07/11/2022 at 3:10 PM, Staff C stated that when he went into the kitchen, he should have worn a hair net.

During an interview, Staff L stated on 07/14/2022 at 6:16 AM that it was her first day and she did not notice a sign that only kitchen staff were allowed in the kitchen. Staff L had been sent to get ice and just went in the kitchen.

During an interview on 07/14/2022, Staff J stated she went to get coffee for a resident with no hair net because it was in the kitchenette which did not require a hair net in this or any other facility she had worked at in the past.

During an interview on 07/14/2022 at 8:40 AM, the Interim Administrator (IADM) stated that if anyone went into the kitchen, they should wear a hairnet. He further stated the front part of the kitchen where the coffee maker and ice machine were located as not considered a part of the kitchen, but he would verify this.

On 07/16/2022 at 5:05 PM, the IADM stated stated hairnets were to be used in the kitchen, including the area where the coffee and ice were located.

2. A review of the policy titled, "Leftovers," dated February 2016, revealed "Leftovers must be cooled to 70 degrees within two hours, then down to 41 degrees within another four hours."

During observations in the kitchen on 07/11/2022 at 2:45 PM, there were two large, deep containers of leftover chicken pot pie dated 07/11/2022, which each held approximately 2 gallons of food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 97	F 812		

The temperature of the contents was noted to be 145 degrees Fahrenheit.

During an interview with the IDM and the Regional DM on 07/11/2022 at 3:02 PM, they indicated the chicken pot pie should have been cooled in a shallow pan so it would reach the correct temperature in the correct time frame. It needed to cool as quickly as possible.

On 07/16/2022 at 5:05 PM, the IADM stated that leftovers must be handled appropriately.

3. A review of the policy titled, "Food Storage-Refrigerated Foods," dated February 2016, revealed "refrigerated foods will be covered, labeled, and dated (month, day, year)." A review of the policy titled, "Leftovers," dated February 2016, revealed "Leftovers will be covered, labeled, and dated."

During observations in the kitchen on 07/11/2022 at 2:45 PM, the following concerns were identified in the reach-in cooler:
a. One container of gravy dated 07/02/2022.
b. One container of potato salad dated 07/03/2022.
c. One container of pears did not contain a date.
d. One container of chili did not contain a date.
e. One container of pork chops dated 07/03/2022.

On 07/16/2022 at 5:05 PM, the IADM stated that foods were to be dated.

4. A review of the Dietary Services Policy and Procedure Manual, dated 02/2016, (Section 6-53) revealed the procedure for cleaning the ice machine. The manual did not specify a frequency for cleaning.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 98	F 812		

Observation of the ice machine on 07/14/2022 at 11:55 AM revealed a black substance on the flap at the top of the inside of the machine.

During an observation and interview on 07/14/2022 at 11:55 AM, the IDM and the Regional DM looked at the ice machine and the black substance on the flap. The Regional DM stated that it did not look very good.

During an interview on 07/14/2022 at 11:57 AM, the Maintenance Director came into the kitchen and stated the ice machine was cleaned every six months, and it was due to be cleaned later this month.

During an interview on 07/14/2022 at 1:00 PM, the ADM stated the ice machine needed to be on a regular schedule for cleaning; she was unsure of the exact schedule.

During an observation and interview on 07/14/2022 at 1:36 PM, the IDM used a paper towel to remove some of the substance from the flap of the ice machine. She stated it was wet, had areas of red and brown, and there was some of the black substance still on the flap of the ice machine. The substance was thicker and more viscous than water.

A review of the Physical Plant Preventative Maintenance Manual (Revised 04/25/2014) revealed monthly/quarterly/semi-annual preventative maintenance for ice machines. A log was provided by maintenance with the semi-annual cleanings documented.

During interview on 07/16/2022 at 5:05 PM, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 99 IADM stated the ice machine should be cleaned on a quarterly basis to de-lime and clean it thoroughly, and it was to be documented on a cleaning schedule. 5. During the initial tour of the kitchen on 07/11/2022 at 9:36 AM, observation revealed two spoons in the handwashing sink. One of the spoons had peanut butter on it and the other spoon had jelly on it. During an interview with the ADM on 07/14/2022 at 1:00 PM, she stated anyone going into the kitchen should know the protocol for the handwashing sink. The ADM stated that staff may have been in the kitchen to make a sandwich for a resident.	F 812		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity;	F 838		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 838	Continued From page 100	F 838		

(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.70(e)(3) A facility-based and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 838	Continued From page 101	F 838		

community-based risk assessment, utilizing an all-hazards approach.
This REQUIREMENT is not met as evidenced by:
Based on facility document review and staff interviews, the facility failed to review and update the facility assessment at least annually and failed to ensure the facility assessment included pertinent information to assure the necessary care and resources were allocated to meet the needs of the residents. The facility identified a census of 64 current residents.

Findings include:

During the entrance conference on 07/11/2022, the Administrator and Interim Administrator were asked to provide a copy of the current facility assessment.

Review of the facility assessment initially presented to the survey team revealed the assessment as dated 01/04/2021. When asked if the facility had a current assessment available, the Administrator and Interim Administrator later provided a copy dated 07/01/2022.

A review of the facility assessment dated 07/01/2022 revealed the top five diagnoses, as coded on the Minimum Data Set (MDS) assessments, history and physical, and Medication Administration Records (MARs), were all the same diagnoses with the same number of residents as listed on the facility assessment dated 01/04/2021. The 2021 report contained the fourth quarter number of residents with the top five diagnoses. These numbers were not included in the 2022 report.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 838	Continued From page 102 Further review of the facility assessments revealed specialty diagnoses were included on both reports, with five listed in 2021 and only the top two of those on the 2022 report. Further review of the 2022 facility assessment revealed the personnel listed on the assessment did not include dietary staff. Also, the assessment did not include any physical space, equipment, assisted technology, or other material resources needed to provide care and services to the residents. The physical environment was not evaluated regarding meeting the needs of the residents (evaluation of building maintenance, capital improvements, vehicles, or equipment and supplies). Also, emergency preparedness was not addressed on the facility assessment. During an interview on 07/15/2022 at 10:22 AM, the Interim Administrator stated the current facility assessment had not been updated beyond what had already been provided to the survey team.	F 838		
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 103 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 104	F 880		

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, record and document review, staff interviews, and facility policy review, it was determined the facility failed to maintain an infection prevention and control program to prevent the transmission of Coronavirus Disease 2019 (COVID-19). Specifically,

1. The facility failed to implement and monitor an effective screening process for staff to prevent a COVID-19 outbreak. The failure to follow facility policy resulted in a staff member being able to work on 07/11/2022 while having signs and symptoms of COVID-19 after having direct exposure to a COVID-19 positive staff member.
2. The facility failed to ensure Resident #38, who tested positive for COVID-19 on 07/05/2022, maintained isolation precautions to ensure staff, residents, and visitors were not exposed to COVID-19.

3. The facility failed to ensure staff working during a COVID-19 outbreak wore N95 masks in accordance with the Centers for Disease Control and Prevention (CDC) guidelines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 105	F 880		

4. The facility failed to ensure N95 masks were fit tested before use.

The facility reported a census of 64 residents. The first COVID-19 positive resident in the facility had been identified on 07/05/2022. Ten residents had tested positive for COVID-19 from 07/05/2022 through 07/15/2022.

It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.80 (Infection Control) at a scope and severity of "K."

The IJ began on 07/11/2022 at 5:30 AM, when Staff A, Dietary Aide, came on duty and worked while having COVID-19 symptoms. The Administrator was notified of the IJ on 07/11/2022 at 6:00 PM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on 07/12/2022 at 4:52 PM. The IJ was removed on 07/15/2022 at 3:15 PM, after the survey team performed onsite verification that the Removal Plan had been implemented. Noncompliance for F880 remained at the lower scope and severity of a pattern, with no actual harm and a potential for more than minimal harm that was not immediate jeopardy.

Findings included:

A review of the facility's policy titled, "Coronavirus Disease (COVID-19) - Infection Prevention and Control Measures," revised July 2020, revealed the screening process included, "2. Anyone entering the facility (including staff) is screened

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 106	F 880		

and triaged for signs and symptoms of and exposure to others with SARS-CoV-2 [severe acute respiratory syndrome coronavirus 2] infection including: a. fever (measured temperature > [greater than] 100 degrees F [Fahrenheit] or subjective fever; b. cough; c. shortness of breath or difficulty breathing; d. fatigue; e. muscle or body aches; f. headache; g. new loss of taste or smell; h. sore throat; i. congestion or runny nose; j. nausea or vomiting; and/or k. diarrhea. 3. Anyone with a fever, signs/symptoms of illness, or who has been advised to self-quarantine due to exposure is not allowed to enter the facility. 4. Residents are screened daily for fever and symptoms of COVID-19. Residents with fever or symptoms of COVID-19 are provided a facemask, immediately isolated, and placed on appropriate transmission-based precautions." Further review of the policy revealed, "For a resident with known or suspected COVID-19: b. Resident is placed in a private room with a dedicated bathroom (if available) and closed door; OR c. Resident is cohorted per national, state, or local public health authority recommendations. 4. If there is a moderate to substantial COVID-19 transmission in the surrounding community: a. Staff wear all recommended PPE [personal protective equipment] (ie. [such as], gloves, gown, eye protection and respirator or facemask) for the care of all residents on the unit (or facility-wide based on the location of affected residents), regardless of symptoms (based on availability). b. Residents are restricted to their rooms except for medically necessary purposes. c. When residents have to leave their room, they wear a face mask, perform hand hygiene, limit their movement in the facility, and practice social distancing."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 107	F 880		

A review of the facility's policy titled, "Personal Protective Equipment Program," revised on 03/12/2004, revealed, "The use of Health Care N95 Particulate Respirator and Surgical Masks will be required to control exposure to contaminated airborne pathogen. Any worker who is required to wear any personal protective equipment (PPE) shall receive training in the proper use and care of the personal protective equipment (PPE)." The policy also indicated, "The training shall include, but not necessarily be limited to, the following subjects: 1. When PPE is necessary to be worn. 2. What PPE is necessary. 3. How to properly put on, take off, adjust, and wear PPE."

1. During an interview on 07/11/2022 at 8:30 AM (the first day of the survey), the Administrator (ADM) stated the facility had three COVID-19 positive residents who were located at the end of 200 Hall. The ADM stated they had positive staff members but was unaware of the exact number.

During an interview on 07/11/2022 at 9:36 AM, Staff A, Dietary Aide, stated he was having signs and symptoms of COVID-19, sore throat, cough, and fever and chills the day before. Staff A stated he checked with the facility the night before and was told if he had no fever and tested negative, even with symptoms, he had to come to work.

During an interview and observation on 07/11/2022 at 9:47 AM, Staff A was walking down the 300 Hall, pushing a meal tray cart, and coughed into his right elbow. Staff A was wearing a KN95 mask and had facial hair that was approximately 1 inch long. Staff A stated, "I'm dying," and that his significant other was at home due to testing positive for COVID-19. Staff A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 108	F 880		

stated he had direct contact with the significant other due to living together and provided meals to them. Staff A stated he woke up on Sunday, 07/10/2022, with a sore throat, cough, and fever. Staff A stated he took Tylenol for the fever and did not currently have a high temperature. Staff A stated the last time they had COVID-19, they tested negative on a rapid test, but tested positive on the PCR test. Staff A stated when they screened in the morning of 07/11/2022 on the screening kiosk, he answered the questions honestly about having symptoms of COVID-19, and the kiosk flagged him for answering yes to some of the symptoms. He stated there had to be an override code in order for him to continue checking in but nobody in the facility knew the override code. He stated his current symptoms were a sore throat, "coughing up green stuff," chills, and body aches. He stated that he was having the same symptoms as the first time he had COVID-19. He stated that he had tried to get the dietary assistant manager to come in to complete his shift. He stated he notified the Interim Administrator (IADM) of his symptoms, who told him he had to stay until there was a replacement. He stated that he called the facility the previous night, 07/10/2022, and spoke to the Minimum Data Set (MDS) Coordinator/Charge Nurse, advising her that he had symptoms of COVID-19. The MDS nurse told him that he had to come to work and wear a mask.

During an interview on 07/11/2022 at 9:56 AM, the Interim Administrator (IADM) and the Administrator (ADM) were interviewed together due to the ADM only being at the facility for one week. The IADM stated that all staff had to ring a doorbell at the front of the facility to enter the facility. Upon entrance, they had to go to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 109	F 880		

screening kiosk to answer the screening questions, and the staff member who opened the door for the staff member had to take their temperature. At that time, the ADM removed her N95 mask and coughed. The IADM stated that if a staff member had symptoms, the screening kiosk would not let them continue to check in, and the staff had to complete a COVID-19 rapid test. If they were negative, they contacted their regional representative to see if the staff member needed to go home or continue working. The IADM stated they did not know who screened in Staff A but were aware that the staff member was flagged for answering "yes" to one or more of the screening questions. The IADM stated nobody in the facility had the override code for the screening kiosk. The IADM stated Staff A notified the IADM that he was not feeling well that morning. The IADM stated he was unaware who Staff A's significant other was or that they were positive for COVID-19. The IADM stated Staff A was waiting for the kitchen assistant manager to call Staff A back, so Staff A could go home. The IADM stated that Staff A should be wearing an N95 mask, not a KN95 mask, and an N95 mask would not fit properly if the staff member had facial hair. The IADM stated Interim Director of Nursing (IDON) A worked the previous night, so the Assistant Director of Nursing (ADON) would answer any questions related to infection control.

At 07/11/2022 at 10:34 AM, the facility sent Staff A home.

During an interview on 07/11/2022 at 10:42 AM, Interim Director of Nursing (IDON) B, who at the time of the interview had not been assigned the title of IDON and was a floor charge nurse, stated that when staff screened in at the kiosk and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 110	F 880		

answered "yes" to any of the questions, "It will pop up that you can't complete it, so you have to have a nurse come look at it." IDON B stated the facility would probably test the staff member and send them home.

During an interview on 07/11/2022 at 10:47 AM, Staff K, Certified Nursing Assistant, stated that when staff screened in at the kiosk and answered "yes" to any of the questions, they had to call one of the nurses or the Administrator. She thought they would be tested but had never been in that situation.

During an interview on 07/11/2022 at 10:57 AM, Staff I, Occupational Therapist, stated if she had symptoms while working, she would notify her boss and go home if the symptoms were beyond her normal symptoms. Staff I stated when staff screened in at the kiosk and answered "yes" to any of the questions, it would flag them. There would be extra screening involved, but Staff I was unsure what type of additional screening would be completed.

During an interview on 07/11/2022 at 11:04 AM, the IADM stated if a staff member tested positive on a rapid test, they would be sent home. The IADM stated if the staff member tested negative and was vaccinated but still had symptoms, he would have to look at the facility policy. The IADM was unable to answer what the facility policy was. The IADM stated if staff had signs and symptoms and tested negative on a rapid test, the facility would monitor them, and they were still allowed to work. The IADM stated the charge nurse monitored staff who screened in, but the IADM was unsure if there was a way to actually monitor the screening process. The IADM stated that staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 111	F 880		

could not enter the building unless another staff member let them in, and that staff member then assisted with the screening of the staff entering the building. The IADM stated if a staff member answered "yes" to one of the screening questions on the kiosk, it sent the IADM an email notification, and the kiosk would not allow the staff to continue with the screening process. The IADM stated again that nobody in the facility had the override code if a staff member answered "yes" to a screening question.

During an interview on 07/11/2022 at 11:13 AM, the Assistant Director of Nursing (ADON) stated if a staff member had symptoms of COVID-19, they should be sent home, even if the rapid test was negative. The ADON stated when staff screened in at the kiosk and answered "yes" to any of the questions, it would send an email to management, and the staff member would be rapid tested.

During an interview on 07/11/2022 at 11:29 AM, the MDS Coordinator stated when staff screened in at the kiosk and answered "yes" to any of the questions, a nurse had to evaluate them, and they were rapid tested. If the staff member tested negative, they were allowed to work, and if they were positive, they would be sent home. The MDS Coordinator stated she understood that if the staff member was negative with symptoms, they had to wear a mask and go to work. The MDS Coordinator stated that Staff A did not call her on 07/10/2022, but his significant other did, and she was aware the significant other was positive for COVID-19. The MDS Coordinator stated the significant other advised the MDS Coordinator that Staff A was having signs and symptoms of COVID-19, and the MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 112	F 880		

Coordinator advised Staff A that he needed to be rapid tested and, if he was negative, he needed to work. If he was positive, he did not need to come into work. The MDS stated she did not notify anyone that Staff A had signs and symptoms of COVID-19. The MDS Coordinator stated if the staff member had obvious signs of COVID-19, then they should stay home. The MDS Coordinator stated she was not aware who was notified if a staff member answered "yes" to one of the screening questions on the kiosk.

During an interview on 07/11/2022 at 11:40 AM, the ADM and IADM stated they had not received a notification that an employee had answered "yes" to one of the questions on the kiosk. The IADM stated that an email should be sent to the ADM and the DON.

During an interview on 07/11/2022 at 11:45 AM, Staff A, who had been sent home, stated he screened in around 5:30 AM on 07/11/2022 and that Staff AA, housekeeper, had screened him in. He stated neither he, nor Staff AA, were aware of what to do when the kiosk would not let him continue screening in, so they both went to work. He stated he was not advised that a nurse had to screen him in. He stated that when the IADM came into work around 8:00 AM, he notified the IADM of his symptoms and that he had tested negative on a rapid test.

During an interview on 07/11/2022 at 3:20 PM, the ADM and IADM stated they were not aware that Staff A was taking Tylenol to decrease his temperature. The IADM stated that after a staff member answered "yes" to one of the screening questions, the kiosk would still allow other staff members to screen in. The IADM stated that at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 113	F 880		

approximately 2:00 PM, the system notified the IADM that a staff member answered "yes" to body aches due to working in the garden during the weekend and was sore. The staff member came to the IADM to let them know the system flagged the staff member. The IADM was asked to provide a copy of the screening report. However, the IADM stated they were not aware of how to access it. The IADM stated that the outbreak started when a newly admitted resident, who was vaccinated, was tested 72 hours after being admitted and tested positive. Two staff members then tested positive, and several days later, another resident tested positive. Subsequently, Resident #38 and his/her roommate tested positive for COVID-19.

During an interview on 07/11/2022 at 3:30 PM, Staff D, Registered Nurse, stated that another staff member had to assist with the screening process by taking the staff's temperature. Staff D stated that if staff had COVID-19 symptoms at work and tested negative, it just depended on how severe the symptoms were if the facility sent the staff member home or not.

During an interview on 07/11/2022 at 4:48 PM, Staff A stated that he had a polymerase chain reaction (PCR) COVID-19 test completed, and the clinic had notified him that he was positive for COVID-19.

During an interview on 07/11/2022 at 5:04 PM, the IADM stated the facility was not in contingency or crisis mode staffing.

During an interview and observation on 07/12/2022 at 8:29 AM, the Maintenance Director stated two more residents tested positive that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 114	F 880		

morning.

On 07/15/2022, a copy of the "Accushield-Health-Screening-Log" dated 07/11/2022 was received and reviewed. The log revealed Staff A screened at 5:36 AM on 07/11/2022 and answered "yes" to the following questions:
- Do you have a cough?
- New Shortness of Breath or Difficulty Breathing
- Fever greater than or equal to 100.0 or Chills>
- Muscle or Body Aches?
- Sore Throat?
- In the last 14 days, outside of work, have you closely interacted with someone for 15 minutes or more, who is now COVID-19 positive?
- Do you live with someone who has NEW symptoms of COVID-19 or has had a NEW positive test?

The "Screening Question Status" indicated Staff A was "Not Cleared." Further review revealed a housekeeper documented Staff A's temperature.

During an interview on 07/13/2022 at 8:41 AM, Interim Director of Nursing (IDON) A stated if a staff member was experiencing signs and symptoms of COVID-19, they should be sent home regardless of whether they tested negative.

During an interview on 07/16/2022 at 10:05 AM, IDON B stated staff who were exhibiting signs and symptoms of COVID-19 were not allowed to work.

During an interview on 07/16/2022 at 4:14 PM, the IADM and ADM stated staff who were exhibiting signs and symptoms of COVID-19 were not allowed to work.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 115	F 880		

Review of an untitled list of COVID-19 positive residents revealed five residents tested positive for COVID-19 from 07/13/2022 through 07/15/2022.

2. A review of Resident #38's "Admission Record" revealed the resident had diagnoses including recurrent depressive disorders, anxiety disorder, and type 2 diabetes.

A review of Resident #38's quarterly Minimum Data Set (MDS), dated 05/12/2022, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident was moderately cognitively impaired. According to the MDS, the resident also had an active diagnosis of non-Alzheimer's dementia.

A review of an untitled list of COVID-19 positive residents indicated Resident #38 tested positive for COVID-19 on 07/05/2022.

A review of Resident #38's "Progress Notes" dated 07/05/2022 at 1:10 PM (late entry) revealed the resident tested positive for COVID-19. According to "Progress Notes" dated 07/05/2022 at 4:00 PM, Resident #38 was sitting at the entry way. Staff members attempted to get the resident to quarantine in the isolation hall and to wear a mask and face shield, and the resident stated he/she was not sick and would not wear a face shield/mask and would not go to a room. The note stated the resident became irritated and threw the face shield and mask in the trash.

A review of "Progress Notes" dated 07/06/2022 at 7:30 AM, revealed when the nurse entered the facility, Resident #38 was sitting at the front door. The nurse attempted to direct the resident to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 116	F 880		

room and to wear a face mask and shield. Resident #38 yelled, "No, I'm not sick and leave me alone."

During an interview on 07/11/2022 at 8:30 AM, the Administrator (ADM) stated the facility had three COVID-19 positive residents who were located at the end of 200 Hall. Resident #38 was observed sitting in the front lobby and was not wearing a mask. The ADM did not identify the resident as being COVID-19 positive at that time.

Further review of "Progress Notes" dated 07/11/2022 at 8:46 AM, revealed staff attempted to get Resident #38 to wear a mask and face shield, and the resident threw them away. Staff then tried to get the resident to go to his/her room, and the resident stated he/she could not leave and was waiting for military command and the police.

During an interview on 07/11/2022 at 2:16 PM, Staff F, Certified Nursing Assistant (CNA), and Staff G, CNA, were asked where Resident #38 was located. Due to a room change, the surveyor was unable to locate the resident during the initial screening process. Both staff stated Resident #38's room was on 100 Hall and was moved to the COVID-19 unit on 200 Hall, but the resident refused to stay in the room. Both staff stated the resident tested positive for COVID-19.

During an interview on 07/11/2022 at 2:40 PM, Staff E, Licensed Practical Nurse (LPN), stated Resident #38 was supposed to be on the COVID-19 unit at the end of 200 Hall, but the resident refused to go behind the plastic barrier. Staff E stated the resident had told her, "That's where sick people go, and I'm not sick." Staff E

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 117	F 880		

stated the resident tested positive for COVID-19 on 07/05/2022. Staff E stated the facility was not allowing other residents out of their rooms, because Resident #38 refused to stay on the COVID-19 unit. Staff E stated the resident was previously in the military and had post-traumatic stress disorder (PTSD), and the resident refused to stay on the unit. Staff E stated Resident #38 sat in the front lobby all day and all night, and the only time the resident moved was to go to use the bathroom in their bedroom on 100 Hall. Staff E stated Resident #38's roommate also tested positive.

During an interview on 07/11/2022 at 3:01 PM, the ADON stated the COVID-19 outbreak started with a resident who left the facility three times a week for dialysis. The ADON stated Resident #8 then tested positive, followed by positive staff members. The ADON stated there were more positive staff than there were residents. The ADON stated they did not have any other residents test positive until a week later, which was Resident #38, followed by Resident #38's roommate. The ADON stated the facility currently had three residents who were COVID-19 positive. The ADON stated they moved Resident #38's belongings to the COVID-19 unit, but the resident refused to move, and the facility stopped communal dining due to Resident #38's refusal to isolate. The ADON stated that Resident #38 ambulated down the 100 Hall, where the resident's room was located, and staff could not direct the resident to the COVID-19 unit. The ADON stated she re-tested the resident to prove to the resident that he/she was positive for COVID-19, but the resident did not believe the results. The ADON stated she offered the resident a face shield and face mask when the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 118	F 880		

resident would sit in the front lobby, but the resident refused to wear them. The ADON stated the resident yelled at her and threw the items in the trash. The ADON stated she had verbally told staff to keep an eye on the resident and to keep the resident away from other residents. The ADON stated the facility put the resident's roommate on "warm isolation," which meant the resident was on isolation, just not on the COVID-19 unit, until the roommate tested positive and was moved.

During an interview on 07/11/2022 at 3:20 PM, the IADM stated the COVID-19 outbreak started when a newly admitted resident, who was vaccinated, was tested 72 hours after being admitted and tested positive. Two staff members then tested positive; several days later, another resident tested positive, then Resident #38 and his/her roommate tested positive for COVID-19. The IADM stated that when a resident tested positive, they were moved to the COVID-19 unit, and the facility tried to keep them in a room by themselves. The IADM stated that Resident #38 would not stay in the room. They kept Resident #38 in an area where there was not a lot of resident contact and stopped communal dining. The IADM stated, "The front area is the best we can do." They could not tell the resident he/she was not allowed to move about the building and could not tell the resident he/she had to stay in the room. The IADM stated that instead, they requested all other residents to stay in their rooms. The IADM stated Resident #38 had the potential to get violent, and there was no choice, other than to reduce the resident's exposure to other residents and staff.

During an interview on 07/11/2022 at 3:30 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 119	F 880		

Staff D, Registered Nurse, stated Resident #38 was noncompliant with staying isolated in his/her room and could become aggressive. Staff D stated all other residents were made to stay in their rooms. Staff D stated he was not aware if Resident #38 was positive for COVID-19.

During an interview on 07/11/2022 at 4:22 PM, Resident #38's family member stated he/she was unaware the resident was positive for COVID-19. The family member stated that within the past three months, the resident started sitting at the front entrance because the resident thought someone was coming to pick him/her up. The family member stated the resident occasionally became aggressive, and the facility had called before when the resident had a bad day. The family member stated the last time the facility contacted him/her regarding the resident's behavior was at the end of April 2022. The family member stated the facility had not contacted him/her regarding the resident's refusal to isolate.

During an interview on 07/11/2022 at 5:04 PM, the IADM stated he tried to redirect Resident #38 to his/her room. The resident had threatened to kill the IADM and also attempted to hit the IADM over the head with a fire extinguisher. The IADM stated the facility had not reached out to their public health contact for guidance and had only contacted their corporate office.

During an interview on 07/12/2022 at 11:09 AM, the IADM stated the facility had not had a Social Service Director (SSD) for a month and a half, and they had someone coming in from another building. The IADM stated that whatever the resident concerns were, the department heads worked on those issues.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 120	F 880		

During an interview on 07/12/2022 at 11:26 AM, the Medical Director (MD) stated the facility reached out to her last Tuesday (07/05/2022) about the outbreak. The MD stated the facility tried to make a plan for Resident #38, but the resident refused to isolate. The MD stated it was not ideal to allow the resident to wander while COVID-19 positive. The MD stated the resident kept coming out of his/her room and would not wear a mask and became aggressive and tried to hit a nurse. The MD stated the lobby became the resident's room, and every activity, dining, or therapy session was one-on-one with residents. According to the MD, it was interesting, because they had not had a spread of COVID-19 and had stopped it from going everywhere. However, the MD stated she was not aware of the recent positive resident cases. She stated the facility should have notified her, but they may have notified the nurse practitioner instead. The MD stated the facility tried to move Resident #38 to another facility, and the MD felt like the resident needed a facility with a secure unit due to being an elopement risk. The MD stated the previous SSD was working on getting the resident to move to another facility; however, the facility no longer had an SSD and was utilizing one from another facility. The MD stated she did not think the resident had been assessed for psychiatric care but felt the resident should be on a secure dementia unit. The MD stated allowing the resident to sit in the front lobby could possibly affect the other residents, and the best option was to keep the other residents isolated. The MD further stated that keeping the other residents isolated could lead to depression. The MD stated she believed the facility was violating the residents' rights, but they were trying to keep the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 121	F 880		

residents healthy.

During an interview on 07/13/2022 at 2:37 PM, the Director of Clinical Operations for Nurse Practitioners (DCONP) stated she did not feel it was appropriate for Resident #38 to be able to ambulate freely throughout the facility while COVID-19 positive. She stated she called her Chief Medical Officer, who stated the facility should transfer the resident to a locked facility due to the resident's behaviors. The DCONP stated she notified the Regional Director of Clinical Services (RDCS) of the recommendation, but the two nearby facilities were full. She stated the facility could send the resident to a local psychiatric facility, but they probably would not take the resident when he/she was COVID-19 positive. She stated she had worked with three different SSDs, and the facility was trying to find the resident another facility. She stated two SSDs had quit because there were no resources around the area.

Further review of an untitled list of COVID-19 positive residents revealed 10 additional residents tested positive for COVID-19 from 07/08/2022 through 07/15/2022.

3. An observation on 07/11/2022 at 9:47 AM, revealed Staff A was walking down the 300 Hall, pushing a meal tray cart, and coughed into his right elbow. Staff A was wearing a KN95 mask and had facial hair that was approximately 1 inch long.

During an interview on 07/11/2022 at 9:56 AM, the Interim Administrator (IADM) and the Administrator (ADM) were interviewed together due to the ADM only being at the facility a week.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 122	F 880		

The IADM stated that Staff A should be wearing an N95 mask, not a KN95 mask, and an N95 mask would not fit properly if the staff member had facial hair. The IADM stated the loops on the N95 mask should fit around the back of the head.

During an interview on 07/11/2022 at 10:51 AM, Staff G, Certified Nursing Assistant, was observed wearing an N95 mask with the top band over the front of the mask and not behind her head. Staff G stated she was, "not sure how to exactly wear it."

During an interview on 07/11/2022 at 10:55 AM, the Maintenance Supervisor (MS) was wearing an N95 mask with the bottom strap underneath his chin and not behind his head. The MS stated, "I'm supposed to wear it over my head. Sometimes I wear it right. I'm used to the KN95, but we can't wear those."

During an interview and observation on 07/11/2022 at 1:53 PM, Staff H, Certified Nursing Assistant, was in Room 108 talking to a resident. Staff H was wearing a face shield and an N95 mask that was below her chin. Staff H placed the mask back on her face and stated the mask should be worn above the nose.

During an interview and observation on 07/12/2022 at 8:29 AM, the MS was again wearing the bottom strap of the N95 mask underneath his chin. When asked why the strap was below the chin, the MS responded, "Ugh. I'm working on it."

4. During an interview on 07/11/2022 at 10:42 AM, Interim Director of Nursing (IDON) B, who at the time of the interview had not been assigned

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 123	F 880		

the title of IDON and was a floor charge nurse, stated she had not been fit tested for the N95 mask she was wearing.

During an interview on 07/11/2022 at 10:42 AM, Staff R, Registered Nurse, stated she had not been fit tested for the N95 mask she was wearing.

During an interview on 07/11/2022 at 10:47 AM, Staff K, Certified Nursing Assistant, stated they had not been fit tested for the N95 mask they were wearing.

During an interview on 07/11/2022 at 10:51 AM, Staff G, Certified Nursing Assistant, stated she had not been fit tested for the N95 mask she was wearing.

During an interview on 07/11/2022 10:53 AM, Staff S, Housekeeper, stated she had not been fit tested for the N95 mask she was wearing.

During an interview on 07/11/2022 at 10:55 AM, the Maintenance Supervisor (MS) stated he had not been fit tested for the N95 mask he was wearing.

During an interview on 07/11/2022 at 10:57 AM, Staff I, Occupational Therapist, stated she had not been fit tested for the N95 mask she was wearing.

During an interview on 07/11/2022 at 10:59 AM, Staff N, Physical Therapy Assistant, stated she had not been fit tested for the N95 mask she was wearing.

During an interview on 07/11/2022 10:59 AM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 124	F 880		

Interim Director of Nursing (IDON) C stated he had not been fit tested for the N95 mask he was wearing.

During an interview on 07/11/2022 at 11:04 AM, the IADM and ADM both stated they had not been fit tested for the N95 mask they were wearing. The IADM stated they had contacted the local health department to complete fit testing; however, the health department would not come to the facility, and the staff members would have to make an appointment and go to the health department to be fit tested for the N95 masks.

During an interview on 07/11/2022 at 11:13 AM, the Assistant Director of Nursing (ADON) stated she had not been fit tested for the N95 mask she was wearing. The ADON stated approximately a year and a half ago, she was fit tested for a different mask.

During an interview on 07/11/2022 at 11:29 AM, the MDS Coordinator stated he had not been fit tested for the N95 mask he was wearing.

During an interview on 07/11/2022 at 3:30 PM, Staff D, Registered Nurse, stated he had not been fit tested for the N95 mask he was wearing. Staff D had facial hair that was approximately ½-inch long and stated he did not believe the facial hair compromised the seal of the mask; however, he felt the facial hair was too long.

During an interview on 07/13/2022 at 8:41 AM, Interim Director of Nursing (IDON) A stated she had not been fit tested for the N95 she was wearing. She had asked about it when she first started working for the facility, and the facility told her they did not do fit testing. She stated she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 125	F 880		

aware that OSHA (Occupational Safety and Health Administration) had fined other facilities for not fit testing for N95s

During an interview on 07/13/2022 at 9:08 AM, Staff Q, Licensed Practical Nurse, stated she had not been fit tested for the N95 mask she was wearing.

Removal Plan:

"How residents affected & residents with potential of being affected were identified: Residents at Northern Mahaska Specialty Care have the potential to be affected.

1. The employee exhibiting signs and symptoms of COVID-19 was sent home on 07/11/2022. A report was run on 7/11/22 to show any other staff who may have coded symptoms. One (1) alert was sent via email and the staff answered a question as yes with aches, but the symptoms were not new or a change from her baseline.

A list of COVID-19 signs and symptoms such as fever, change in cough, change in body aches, shortness of breath, fatigue, sore throat, loss of taste and smell, nausea, vomiting, and diarrhea were reposted at the Accushield screeners for a quick reminder to not enter the facility if exhibiting any of the signs or symptoms listed.

Accushield alerts have been assigned to the facility administrator via email. If the system is down, a paper copy will be monitored for symptomatic staff and/or visitors.

Current facility staff and Agency staff including department managers have been educated by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 126	F 880		

nursing management on not entering the facility if they have had direct exposure to COVID-19 and are not up to date with vaccination status and/or experiencing signs and symptoms of COVID-19. Education began on 7/11/22 and will continue till completed on 7/14/22. Staff not currently in the center will be called and educated. If staff are off on leave or vacation, they will be educated prior to working.
Administrator and/or Director of nursing will complete daily Accushield audits per alert notification on current staff x [times] 6 weeks to ensure screening is appropriately completed.

2. The resident refusing to isolate or wear a mask was provided with 1:1 [one-on-one] staff to assist in keeping him isolated within a designated COVID-19 unit. If the resident continues to refuse to wear a mask or stay on the isolated unit, staff will continue to provide 1:1 to maintain social distancing regardless of time of day until isolation is no longer required after the ten-day mark 7/15/22. The staff providing 1:1 will inform facility management of continued noncompliance. The primary care physician and [family member] was notified of the resident currently refusing to follow recommendations.

Current Facility staff and agency staff have been educated by nursing management such as DON, ADON, and/or nurse manager that if a resident tests positive for COVID-19 and the resident refuses to be placed in isolation, the resident will go 1:1 with a staff member to ensure the resident does not have contact with any outside visitors or residents and remain 6 foot apart from other residents and visitors. The staff will assist in redirection of the resident to the COVID-19 isolation unit and encourage mask use. Education

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 127	F 880		

began on 7/11/22 and will continue till completed on 7/14/22. Staff not currently in the center will be called and educated, if staff are off on leave or vacation, they will be educated prior to working.

3. Current Facility staff on the clock, including agency staff have been educated by nursing management that during a COVID-19 outbreak, they are to wear N95s that cover the nose and with both straps around the head. If staff have facial hair, they should remove the facial hair to ensure proper fitting of mask. Education began on 7/11/22 and will continue till completed on 7/14/22. Staff not currently in the center will be called and educated. If staff are off on leave or vacation, they will be educated prior to working

Monitoring for compliance by Observing the staff with PPE [personal protective equipment] compliance will continue daily by the department managers for six weeks then monthly staff will be immediately re-educated to proper PPE use.

Anticipated date of completion for this plan of correction [immediate jeopardy removal plan] 07/14/2022."

Onsite Verification:
The IJ was removed on 07/15/2022 at 3:15 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Onsite verification of the Removal Plan began at 2:30 PM on 07/14/2022, when Staff A was verified to be sent home on 07/11/2022. Verification of the COVID-19 signs and symptoms list posted at the Accushield screener was completed on 07/13/2022. A total of 36 staff interviews were conducted with staff from all three shifts to verify training had been completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 128 The staff interviewed included Certified Nursing Assistants (CNAs), Licensed Practical Nurses (LPNs), Registered Nurses (RNs), housekeeping staff, environmental services staff, kitchen staff, the beautician, the Activity Director, the scheduler, a hospice social worker, and an occupational therapy staff. The staff interviewed verified they had been trained on not entering the facility if they had direct exposure to COVID-19 and were not up to date with vaccination status and/or experiencing signs and symptoms of COVID-19; if a resident tested positive for COVID-19 and the resident refused to be placed in isolation, the resident would be placed 1:1 with a staff member to ensure the resident did not have contact with any outside visitors or residents and remained six feet apart from other residents and visitors; during a COVID-19 outbreak, they were to wear N95s that covered the nose and with both straps around the head. If staff had facial hair, they should remove the facial hair to ensure proper fitting of the mask. A review of the in-service sheets provided indicated that all 46 staff members had been provided training. Those staff who were not physically present to receive the in-services were messaged via telephone, with the in-service information provided and the employee acknowledging receipt and voicing understanding.	F 880		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 129 and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. BUILDING _____ B. WING _____	07/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN MAHASKA SPECIALTY CARE	2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 130	F 886		

consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state
and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interviews, and facility policy review, the facility failed to maintain documentation to ensure the facility completed COVID-19 outbreak testing per the Centers for Medicare and Medicaid Services (CMS) guidelines during a COVID-19 outbreak. The facility identified a census of 64 current residents.

Findings include:

Review of the facility's policy titled, "COVID-19 Testing Policy," updated 03/15/2022, revealed, "Facilities must demonstrate compliance with the testing requirements. To do so, facility should do the following: Upon identification of a new COVID-19 case in the facility, document the date the case was identified, the date that other residents and staff are tested, the dates that staff and residents who tested negative are retested, and the results of all tests."

During an interview on 07/11/2022 at 10:42 AM,

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	165274	A. BUILDING _____ B. WING _____	07/16/2022

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F 886	Continued From page 131	F 886		

Interim Director of Nursing (IDON) B stated the facility was testing staff for COVID-19 twice a week.

During an interview on 07/11/2022 at 10:47 AM, Staff K, Certified Nursing Assistant (CNA), stated the facility was testing staff for COVID-19 twice a week.

During an interview on 07/11/2022 at 10:51 AM, Staff G, CNA stated the facility was testing staff for COVID-19 twice a week.

During an interview on 07/11/2022 at 10:57 AM, Staff I, Occupational Therapist, stated the facility was testing staff for COVID-19 twice a week.

During an interview on 07/11/2022 at 3:30 PM, Staff D, Registered Nurse, stated the facility was testing staff for COVID-19 twice a week.

During an interview on 07/11/2022 at 11:04 AM, the Interim Administrator (IADM) stated the facility was testing staff twice weekly, either on Monday/Thursday or Tuesday/Friday.

During an interview on 07/11/2022 at 11:13 AM, the Assistant Director of Nursing (ADON) stated the facility tested staff twice weekly on Tuesday and Thursday.

During an interview on 07/11/2022 at 11:29 AM, the Minimum Data Set (MDS) Coordinator stated the facility was testing staff for COVID-19 twice a week.

During an interview on 07/12/2022 at 11:26 AM, the Medical Director (MD) stated the facility was testing staff for COVID-19 twice a week.

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F 886	Continued From page 132	F 886		

During an interview on 07/13/2022 at 8:41 AM, Interim Director of Nursing (IDON) A stated the facility was testing staff for COVID-19 twice a week.

During an interview on 07/11/2022 at 1:00 PM, the IADM was asked for copies of the facility's COVID-19 testing log. The IADM stated the nurses pulled individual testing forms to verify that staff were being tested, and the facility did not have a testing log. The IADM stated that staff just go off of 'those sheets' and did not know how the facility was monitoring to ensure the testing was being completed twice a week.

During a follow-up interview with the IADM on 07/12/2022 at 11:21 AM, the IADM stated they kept staff testing sheets in order by day, and again stated the facility did not have a log. The IADM stated the only way they verified completed staff testing was by keeping the sheets in order by date. He stated the facility had not gone back to validate the information and ensure all staff were being tested. The IADM stated the facility changed their reporting process about one to two months ago, per the previous Administrator.

During an interview on 07/13/2022 at 12:24 PM, the Assistant Director of Nursing (ADON) stated the facility currently tested staff members twice a week. The testing fluctuated due to the county rate and if they had any COVID-19 positive staff or residents in the building. The ADON stated there was no reason the facility hadn't kept track of a log and the previous Administrator said staff did not have to any more.

During an interview on 07/16/2022 at 10:05 AM,

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F 886	Continued From page 133 IDON B stated the facility should have a log to monitor COVID-19 testing to verify they were following the testing schedule. IDON B stated they used to complete a log but had stopped. During an interview with the Administrator (ADM) and the IADM on 07/16/2022 at 4:14 PM, the IADM stated the facility should have a log that monitored COVID-19 testing to verify they were following the testing schedule. According to the IADM, the facility now had a log. When the surveyor requested a copy of the log, and the ADM stated she got distracted and didn't get it done, and asked the IADM for assistance with creating the log.	F 886		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observations, and staff and contractor interviews, the facility failed to maintain an effective pest control program, as evidenced by the presence of flies in the kitchen. The facility identified a census of 64 current residents. Findings include: A review of the facility policy titled, "Pest Management," dated February 2016, from the Dietary Services Policy and Procedure Manual revealed "If a pest situation is reported, the contractor comes in as soon as possible to treat at the appointed times." The policy also indicated,	F 925		

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F 925	Continued From page 134	F 925		

"Any pest traps that are in the kitchen area will be monitored daily and disposed of according to the contractor's specifications."

During an observation in the kitchen on 07/11/2022 at 2:45 PM, several flies were observed in the back portion of the kitchen.

During another observation in the kitchen on 07/14/2022 at 12:05 PM, flies were observed near the tray line and by the plate covers (approximately six to eight flies flying around the area).

During an interview on 07/14/2022 at 12:20 PM, Staff M, Cook, stated there had been flies in the facility's kitchen. Staff M stated it had been reported to the Maintenance Director with no change noted.

During an interview on 07/15/2022 at 7:50 AM, the Interim Dietary Manager (IDM) stated that flies had been a problem for the last month, and they were generally worse in the back. The IDM stated that the Maintenance Director (unavailable due to illness) told her there was nothing more he could do.

A phone interview on 07/15/2022 at 12:33 PM with the receptionist from the facility's contracted pest control company indicated the facility had a contract for a large fly service, which included traps in the kitchen and dining room as well as strips to catch flies. The receptionist stated that was all she could determine from the notes available.

On 07/16/2022 at 5:01 PM, the Interim Administrator (IADM) stated that if there were

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F 925	Continued From page 135 flies in the facility, it was the expectation that maintenance staff would check fly traps and evaluate if there was another reason for the flies being in the building. He stated that it could result from the back door being open. The IADM agreed that the door could contribute to the flies being in the building.	F 925		