STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165589	A. BUILDING _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSKALOOSA CARE CENTER	605 HIGHWAY 432 OSKALOOSA, IA 52577

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F 000	INITIAL COMMENTS Correction date 6/26/2025 The following deficiencies resulted from the facility's Annual Recertification Survey and investigation of Facility Reported Incidents #127850-I, #129145-I, 129264-I and 128868-M conducted June 16, 2025 to June 19, 2025. Facility Reported Incident #127850-I, #129145-I and 129264-I did not result in a deficiency. Findings for Facility Reported Incident #128868-M will be sent to the facility at a later date under a separate cover. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is	F 605		

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

Tina Griffin — Administrator — 7-1-2025

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F 605	Continued From page 1 not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a	F 605		

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F 605	Continued From page 2 comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and policy review, the facility failed to limit a PRN	F 605		

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F 605	Continued From page 3 (as needed) psychotropic drug (drugs that affect a person's mental state) to 14 days and failed to ensure the resident had an appropriate diagnosis for the psychotropic drug for 1 of 6 residents reviewed (Resident #28). The facility reported a census of 81 residents. Findings include: According to the Minimum Date Set (MDS) assessment dated 5/21/25 Resident #28 scored 13 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The resident did not have a diagnosis of anxiety and did not have physical, verbal or other behavioral symptoms directed towards others and scored a 0 on the resident mood interview (PHQ-2, Patient Health Questionnaire) which indicated no depression or minimal depression symptoms. The resident received an antianxiety medication during the 7 day look back period. The Electronic Health Record (EHR) lacked a diagnosis of anxiety or other mood disorders for Resident #28. The EHR (Feburary 2025 Medication Administration Record) for Resident #28 included an order for Lorazepam (medication to treat anxiety disorders) oral tablet 0.5 mg (milligrams), give 1 tablet by mouth every 4 hours as needed for anxiety, not to exceed 3 doses per 24 hour period, with a start date of 2/19/25 and a discontinue date of 3/15/25. The Medication Administration Record (MAR) for the month of February and March revealed Lorazepam was administered to the resident 7 of the 10 days in February and 11 of the 15 days in March.	F 605		

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F 605	Continued From page 4 The EHR for Resident #28 included an order for Lorazepam oral tablet 0.5 mg, given 1 tablet by mouth every 4 hours as needed for anxiety, not to exceed 5 doses per 24 hour period, with a start date of 3/15/25 and a discontinue date of 5/15/25. The MAR for the months of March, April and May revealed Lorazepam was administered to the resident 17 of the 17 days in March, 30 of the 30 days in April and 15 of the 15 days in May. The EHR for Resident #28 included an order for Lorazepam oral tablet 0.5 mg, give 1 tablet by mouth every 4 hours as needed for anxiety, with a start date of 5/15/25 and no end date. The MAR for the months of May and June revealed Lorazepam was administered to the resident 17 of the 17 days in May and 19 of the 19 days so far in June. The EHR for Resident #28 included a Pharmacist Medication Regimen Review (MRR) dated 2/19/25, recommending the facility review this resident's PRN Lorazepam under the 14 day rule for PRN psychotropic's, be sure that it is discontinued, or evaluated and given a stop date. The EHR lacked a response by the facility to the MRR. The EHR for Resident #28 included a Pharmacist MRR dated 5/16/25, referencing the MRR dated 2/19/25 for the PRN Lorazepam 14 day rule, with a recommendation status from the facility as no response. During an interview 6/19/25 at 1:00 PM the Director of Nursing (DON) acknowledged the facility did not respond to the pharmacy recommendations regarding the PRN Lorazepam for Resident #28 and acknowledged the resident	F 605		

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F 605	Continued From page 5 did not have an appropriate diagnosis for the anti-anxiety medication. The DON stated the resident became anxious when she had difficulty breathing and would request the Lorazepam. During an interview 6/19/25 at 1:44 PM the Administrator stated an expectation PRN psychotropic medications not exceed the initial 14 days without a rationale to extend the medication by the physician. The Administrator further stated an expectation the resident should have an appropriate diagnosis for the psychotropic medication. Review of the facility Medication Regimen Review policy, undated, documented the MRR will be completed by a consultant pharmacist and the DON will forward to the physician the MRR findings that require their response.	F 605		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		

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F 656	Continued From page 6 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)- (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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and policy review, the facility failed to develop and implement a comprehensive person centered Care Plan for 1 of 19 residents reviewed for Care Plans (Resident #28). The facility reported a census of 81 residents. Findings include:	F 656		

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F 656	Continued From page 7 According to the Minimum Date Set (MDS) assessment dated 5/21/25 Resident #28 scored 13 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The resident had diagnoses to include debility, cardiorespiratory conditions, heart failure, asthma and respiratory failure. The resident did not have any psychiatric/mood disorder diagnoses. The resident received an antianxiety medication during the 7 day look back period. The EHR (February 2025 Medication Administration Record) for Resident #28 included an order for Lorazepam (medication to treat anxiety disorders) oral tablet 0.5 mg (milligrams), give 1 tablet by mouth every 4 hours as needed for anxiety, with a start date of 2/19/25. This medication continued through June of 2025, as a PRN for anxiety, given to the resident daily since March. The Care Plan for Resident #28, with an initiation date of 1/14/25, lacked a focus area, goal and interventions for anti-anxiety medication and behavior monitoring for the use of the anti-anxiety medication and possible side effect monitoring. During an interview 6/19/25 at 1:15 PM the Assistant Director of Nursing (ADON) acknowledged the Care Plan for Resident #28 did not include a focus area, goal or interventions/tasks related to the resident being on an anti-anxiety medication and stated an expectation this should be in the care plan. During an interview 6/19/25 at 1:44 PM the Administrator stated an expectation the Care Plan for Resident #28 include a focus area, goal and interventions/tasks related to the resident being	F 656		

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F 656	Continued From page 8 on an anti-anxiety medication. Review of the facility Clinical Care Management policy, dated 5/2014, documented clinical care management includes routine assessment, evaluation and response to changes in clinical condition and update the care plan as indicated.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews record review and policy the facility failed to follow professional standards during medication administration observation, left medications with a resident, unsupervised administration for 1 of 7 observed (R#45). The facility reported a census of 81. Findings include: The Quarterly Minimum Data Set (MDS) dated 5/28/25 documented the diagnoses for Resident #45 included progressive neurological conditions, Parkinson's disease, heart disease and depression. The resident's Brief Interview for Mental Status (BIMS) score was 15 of 15 indicated cognition intact. The Care Plan focus dated 1/4/24 revealed Resident #45 had a physician's order for unsupervised self administration of the following medications: muscle rub. The goals to	F 658		

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F 658	Continued From page 9 demonstrate the ability, interventions included to assess resident's ability to safely self-administer medications, to discuss medications with each supervised administration, to demonstrate, monitor, provide written documentation on each medication for resident to keep at the bedside. In an interview on 6/18/25 at 8:23 AM, Licensed Practical Nurse (LPN), Staff A, voiced resident is approved for self-administration of medications, had an order, can leave medications at the table for resident self administration, would return to ensure was taken. Observation on 6/18/25 at 8:25 AM, LPN, Staff A placed nine (9) pills for Resident #45 into a medication cup included: 1. Carbidopa/Levodopa 25-100 milligram (mg) 2. Carvedilol 6.25 mg 3. Gabapentin 100 mg 4. Losartan pot 25 mg 5. Aspirin 81 mg 6. Multivitamin tablet 7. Vitamin B complex 8. Vitamin E 400 units 9. Calcium 1200 mg with Vitamin D3 Observation 6/18/25 at 8:30 AM, LPN, Staff A proceeded to the main dining room and placed the medication cup with pills in front of Resident #45 who sat at the dining room table with two other residents. LPN, Staff A, left and returned to the medication cart in another hallway. In an interview on 6/18/25 at 12:30 PM, Resident #45's responsible party visited, relayed Resident #45 relied on staff for giving medications, is no orders for self-administration of pills, felt that	F 658		

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F 658	Continued From page 10 would not be allowed. On 6/19/25 at 12:15 PM, Registered Nurse (RN), Staff B, relayed the Care Plan outlined self administration of medication, muscle rub. Resident #45 had a locked box in the room however, had not been able to use the cream independently, felt processes for independent use was left in place since offered resident a sense of security. On 6/19/25 at 1:00 PM, The Administrator voiced no medications should ever be left unattended, would be a risk for another resident to take, acknowledged Resident #45 medications should of been witnessed by the nurse to ensure took appropriately. The facility policy titled, Medication Administration dates 1/2013 documented procedure included to remain with the resident until all medication is taken.	F 658		
F 812 SS=E	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.	F 812		

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F 812	Continued From page 11 (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 observation, staff interviews, record review and policy review, the facility failed to ensure open items were dated, covered and labeled and food was stored under sanitary conditions to prevent cross contamination. The facility further failed to test twice daily the dishwasher to ensure the low temperature dishwasher was getting to the correct temperatures and chemical solution to appropriately sanitize dishes. The facility reported a census of 81 residents. Findings include: During a continuous observation 6/16/25 beginning at 10:45 AM of the pantry and refrigerator with the Dietary Manager (DM) present revealed the following: 1. Open, undated bag of graham cracker crumbs. 2. Open, undated bag of powered sugar. 3. Open, undated bag of quick rise soft roll mix. 4. Open bag of muffin mix, with an opened date of February 2025. 5. A full pan of frozen shredded pork thawing in the refrigerator on a shelf above a shelf of eggs. A record review of the dishwasher temperature and sanitization chemical strip test log maintained by the facility revealed several dates missing in the previous three months. In the month of	F 812		

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F 812	Continued From page 12 March 2025, there were 18 days that did not have documentation for the temperature and chemical test strip test of the dishwasher. In the month of April, 2025, there were 8 days and in the month of May there were 18 days. An observed test of the low chemical dishwasher completed on 6/16/25 at 11:00 AM revealed appropriate temperatures and chemical solution. During an interview 6/16/25 at 10:55 AM, the DM stated an expectation thawing meat should not be placed above other food items in the refrigerator and acknowledged the pan of thawing meat was placed above a shelf of eggs. The DM stated an expectation food should be dated when opened and used within a short time of the open date. The DM stated an expectation the dishwasher temperature and chemical sanitizer test strip should be conducted and documented daily, both on the AM shift and the PM shift and acknowledged this had not taken place for several days in the past three months. The DM stated she had provided education to staff. During an interview 6/18/25 at 1:38 PM, the Administrator stated an expectation thawing meat should be on the bottom shelf with no other food below it and an expectation food that has been opened have an open date and thrown away if not consumed within a short time. The dishwasher temperature and chemical checks should be completed twice daily and documented. A review of the facility Sanitation and Food Production policy, dated 6/15, documented foods are thawed properly to prevent food borne illness and frozen meats placed on the lowest shelves in the refrigerator to prevent juices from dripping	F 812		

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F 812	Continued From page 13 onto other foods and causing cross contamination. A review of the facility Food Labeling Reference Guide policy, dated 6/2015, documented when food item is opened and not completely used, write the open date on the food container and a use by date on the food container. Mixes should be used within 7 days of the open date. A review of the facility Dish Machine/Sanitizer Log policy, dated 6/2015, documented to monitor and record once a shift the sanitizing concentration for low temperature dish machine.	F 812		
F 880 SS=D	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: §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 §483.71 and following	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165589	A. BUILDING _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSKALOOSA CARE CENTER	605 HIGHWAY 432 OSKALOOSA, IA 52577

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F 880	Continued From page 14 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. §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.	F 880		

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F 880	Continued From page 15 §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 direct observation, clinical record review, staff interview, and facility policy review, the facility failed to perform perineal care for incontinent residents in a hygienic manner for 3 of 3 residents observed (Resident #1, #38, and #63). The facility reported a census of 81. Findings include: 1. The Annual Minimum Data Set (MDS) for Resident #1, dated 11/27/2024, documented the resident incontinent and was fully dependent on staff members for toileting hygiene and incontinence care. The care plan for Resident #1, last revised 06/18/2025, also documented the resident was fully dependent on staff members for toileting and hygiene. During a direct observation on 06/18/2025 at 10:25 am, revealed Staff C, Certified Nurse's Aide (CNA), and Staff D, CNA, performing perineal cares and toileting hygiene for Resident #1. During the cleaning of the resident, both Staff C and Staff D disposed of the gloves they were using during cares and continued to provide cares and help the resident dress, making direct ungloved contact with the resident's buttocks. 2. The MDS for Resident #38, dated 06/11/2025, documented the resident was incontinent and	F 880		

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F 880	Continued From page 16 fully dependent upon staff for perineal cares and toileting hygiene. The care plan for Resident #38, last revised 03/31/2025, documented the resident was dependent on staff for hygiene and required staff assistance to use the toilet. During a direct observation on 06/18/2025 at 11:36 AM, Staff E, CNA, was observed performing perineal cares for Resident #38. During cares a privacy curtain was not fully closed and Staff E used gloves soiled with what appeared to be feces to close the curtains before continuing to clean the resident. After cleaning the resident's perineal area, Staff E removed the gloves and continued to help the resident dress, making bare skinned contact with the resident. Hand hygiene was not performed after removing the gloves and making contact with the resident. 3. The MDS for Resident #63, dated 04/23/2025, documented the resident was always incontinent and was dependent on staff for toileting hygiene. The care plan for Resident #63, last revised 04/28/2025, documented the resident was fully dependent on staff for perineal cares and toileting hygiene. During a direct observation on 06/18/2025 at 12:23 PM, Staff C, CNA, took off her gloves during perineal cares and continued to provide care for Resident #63 without gloves, making bare skin contact with the resident's perineal area and groin. In an interview on 06/19/2025 at 03:32 PM with Staff F, CNA, she stated gloves are essential	F 880		

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F 880	Continued From page 17 when performing perineal care and hygiene cares on a resident. She stated there is no way she would ever place a clean adult brief on a resident without gloves. She also stated the perineal care checklist states CNAs are to wear gloves during every step of the perineal care process. In an interview on 06/19/2025 at 03:16 PM, Staff G, Licensed Practical Nurse (LPN), stated that during perineal cares she is instructed to wear gloves during the entire process. In an interview on 06/18/2025 at 12:39 PM with the Director of Nursing (DON), she immediately acknowledged the bare skin contact of Staff C with Resident #63 was inappropriate, as she was witness to the perineal care process for that resident. She stated all staff members need to be wearing gloves at all times. A policy regarding perineal cares was requested but not provided during the survey process.	F 880		

The Plan of Correction as documented on 2567 constitutes my credible allegation of compliance and the stated deficiency was corrected June 26, 2025

PLAN OF CORRECTION

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because the provisions of federal and/or state law require it.

F 605

Oskaloosa Care Center will continue to keep residents free from Chemical Restraints.

1. Resident #28 now has a diagnosis of anxiety.

2. The facility received an order from the physician on 6/19/2025.

3. The DON or designator will conduct audits of PRN orders and report findings to the QAPI Committee

4. Ongoing monitoring of PRN medication and Diagnosis will be reported to the QAPI committee.

Completion Date: June 20,2025

PLAN OF CORRECTION

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F 656

Oskaloosa Care Center will continue to develop and implement a comprehensive person-centered care plan for each resident.

1. Resident #28 has a developed and implemented plan of care that is comprehensive person-centered care.

2. Education to the MDS coordinator has been given by the Director of Nursing to ensure that

care plans include a focus area, goal or interventions/tasks related to residents being on an anti-anxiety medication

3. Review of resident Care Plans will include routine assessment evaluation and response to changes in clinical condition and updated.

4. Ongoing audits of Care Plans and focus area, goal and interventions are updated and will become part of the facility's Quality Assurance process.

Completion Date: June 20, 2025

PLAN OF CORRECTION

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F 658

Oskaloosa Care Center will continue to follow professional standards during medication administration.

1. Resident 45 will continue to self-administrate muscle rub. Resident # 45 will continue to have medications witnessed by the nurse to ensure taken appropriately.

2. Staff A have been educated and updated on medication administration. An in-service was provided to all nurses on the policy on medication administration on June 26 2025, by the Director of Nursing.

3. The Director of Nursing, and or designator will audit the medication administration by all nursing and/or Certified Med Aides.

4. Ongoing audits will become part of the facility's Quality Assurance process.

Completion Date: June 26, 2025

PLAN OF CORRECTION

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F 812

Oskaloosa Care Center will continue to ensure dietary staff store, prepare, distribute and serve food in accordance with standards for food safety.

1. Residents at Oskaloosa Care Center will continue to have food safety requirements provided.

2. Re-education was provided on June 26th, 2025, to dietary staff employed at Oskaloosa Care Center; when food items are opened and not completely used, on dish machine sanitation log to document and monitor dish machine temperature and the proper way of thawing of meat.

3. The Dietary Service Manager/designee will complete audits to ensure dietary staff are following sanitary and food storage.

4. Ongoing monitoring of food sanitation and food storage safety for residents will become part of the facility Quality Assurance process and QAPI.

Completion Date: June 26,2025

PLAN OF CORRECTION

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F880

It is the facility practice implementing infection control practices to prevent the spread of disease

1. Residents #1, #38 and #63 are receiving proper peri care when incontinent. The facility has established and maintained an infection control program for preventing, identifying, reporting, investigation, and controlling infection control.

2. Immediate staff training was provided on 06/18/2025 to staff C, staff D, Staff E and Staff F; additional staff training was provided on June 24, 2025, to ensure the proper use of gloves.

3. DON/ designee will complete audits to ensure proper glove and handwashing usage are completed when doing perineal care and hygiene cares on resident

4. Compliance will be monitored by the QAPI Committee

Completion Date: June 26, 2025

A root cause analysis will and is being conducted by the facility and will be completed no later than 12/04/2020, documentation will be provided to Iowa Dept. of Inspections and Appeals upon completion.

The Plan of Correction as documented on 2567 constitutes my credible allegation of compliance and the stated deficiency was corrected June 26, 2025

PLAN OF CORRECTION

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2. Staff A have been educated and updated on medication administration. An in-service was provided to all nurses on the policy on medication administration on June 26 2025, by the Director of Nursing.

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