STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165576	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ossian Care Center	114 FISHER STREET , OSSIAN, Iowa, 52161

(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
✓ F0000 KBS	INITIAL COMMENTS Correction date: 12/2/2025 The following deficiencies resulted from investigation of facility reported incident #2620217-I conducted October 15, 2025 to October 20, 2025. Facility reported incident #2620217-I resulted in a deficiency. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000	**F0000 Initial Comments:** The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies were executed solely because provisions of State and Federal law require it.	
F0684 SS = D	Quality of Care CFR(s): 483.25 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff, Pharmacist, and Physician interview the facility failed to provide timely interventions and notification to the resident's Physician after a resident presented with a low blood pressure. was lethargic, drowsy, and had blood pressure of 63/36 millimeters of mercury (mmHg) (normal blood pressure is considered to be less than 120/80 millimeters of mercury (mmHg) for one of three residents reviewed for assessment and intervention (Resident #1). The facility reported a census of 40 residents. Findings include: The Minimum Data Set (MDS) assessment dated 9/11/25 for Resident #1 documented a Brief Interview for Mental Status (BIMS) of 11, which indicated moderate cognitive	F0684	**F 684** **Immediate corrective action:** Resident #1's blood pressure was reassessed at 0600 by DON and ADON, and contacted physician for order to transport to the emergency department for evaluation. ADON and DON educated Staff D on blood pressure parameters. 9/16/2025 **Who is affected:** All residents have potential to be affected. **Measures altered to correct problem:** • Resident #1's care plan revised to monitor/document side effects, effectiveness, and vital signs while narcotic is administered. 9/20/2025	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachael Marshall	Administrator	✓12/2/2025

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F0684 SS = D	Continued from page 1 impairment. The MDS also identified the resident was dependent (staff did all the effort) for assistance with transfers and partial to moderate assistance (staff did less than half the effort) with bed mobility. The MDS include diagnoses of hypertension, heart failure, anemia, and fracture. Review of Resident #3's Skilled Charting assessment dated 9/16/25 at 11:02 PM, locked on 9/17/25 at 12:06 AM, documented vital signs of temperature 97.6 degrees Fahrenheit (F) (normal temperature 97-99 F), pulse 89 beats per minute (bpm) (normal 60-100 bpm) respiration of 16 (normal respirations 16-20), blood pressure of 63/36 mmHg (normal blood pressure, top number less than 120 and bottom number less than 80) lying down, and with a recheck blood pressure of 61/50. The document reported the resident presented as very drowsy and did answer but slept through assessment and denied pain. Review of Resident #1 Medication Administration Record (MAR) for September 2025 documented the following opioid (a type of drug that acts on the body's opioid receptors to reduce the intensity of pain signals) medication orders effective on 9/17/2025: Fentanyl patch 12 micrograms (mcg) change every three (3) days and Hydromorphone 1 milligram (mg) every six (6) hours. Review of Resident #1's ED Provider Notes from the Hospital, dated 9/17/25 at 8:11 AM, documented a chief complaint of altered mental status with low blood pressure. Review of Physical Exam section revealed Resident #1's temperature 97.9, pulse 98, respirations 29, blood pressure 89/54, and oxygen 93% (normal above 90%). The ED Provider Notes further revealed the resident had a recent thoracic spine fracture that was not operable and had been having trouble with pain management. [Resident #1] was having delusions when he was on Dilaudid (Hydromorphone), medication was decreased, [Resident #1 received Fentanyl patches, and was recently started on Risperdal 1 milligram (an antipsychotic medication, it is believed to work by balancing levels of dopamine and serotonin in the brain) twice a day. Per the primary care team the Risperdal did help the delusions as well as decreasing his Dilaudid dose. However, since last night [Resident #1] has had decreased blood pressure and altered mental status. Review of the Care Plan for pain medication therapy (Hydromorphone) included the following inventions, both dated 9/20/25: Hold medication if [Resident #1] was lethargic and/or had decreased responsiveness. Per Provider, if [Resident #1's] systolic (top number) of	F0684	• Nursing staff educated on vital sign parameters and adverse narcotic reactions. 10/20/2025 • All residents' vital signs were reviewed for abnormalities or values outside of physician-ordered parameters. No abnormalities were identified, and no resident required further intervention. 10/19/2025 • Medications requiring vital signs have been reviewed and updated with the appropriate hold parameters per healthcare provider orders. The EMAR has been updated to clearly indicate when medications are to be held based on vital sign thresholds. All updates were completed on 12/1/2025. **Plan to monitor performance:** DON/Designee will complete periodic audits to ensure vital sign parameters are in place for all residents and nursing staff knowledge is being retained through education. Audits will be monthly, and results will be tracked and trended at QAPI to ensure compliance.	

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F0684 SS = D	Continued from page 2 the blood pressure is less than 90 and/or diastolic (bottom number) is less than 60, update the provider or on call provider. An interview on 10/16/25 at 9:06 AM with Resident #1's Physician revealed he would expect to be notified of blood pressures lower than 90/50 mm/Hg. An interview on 10/16/25 at 9:24 AM with Staff D, Licensed Practical Nurse (LPN) explained the Physician increased risperidal from 0.5 mg to 1 mg, and thought low blood pressure was related to the increased dose. The resident did not sleep well the night prior and he was responsive when given his scheduled dilaudid. Staff D explained a blood pressure lower than 90/50 would require a physician notification. Staff D also explained she tried different blood pressure cuffs as she thought it was an error blood pressure reading. An interview on 10/16/25 at 11:01 AM with the facility's Pharmacist informed she would have thought a nurse would call the Physician if there was a concern related to a low blood pressure. An interview on 10/16/25 at 2:56 PM with Staff E, Certified Nursing Assistant (CNA) informed she observed Resident #1 on 9/17/25 around 12:30 AM and had no concerns with him at the time. She then revealed she observed Resident #1 more than 20 times throughout the night, and he was the same. She also revealed the nurse checked on him frequently. She then informed at about 5:30 AM his eyes were glazed and he appeared different. An interview on 10/20/25 at 2:48 PM with the Assistant Director of Nursing (ADON) revealed on 9/17/25 at approximately 6:20 AM she assessed Resident #1 with Staff D and noticed he did not present as he normally did, she assessed his blood pressure and it read 84/62. She then informed she would have expected Staff D to reassess Resident #1 blood pressure when it was 60/36 with a manual blood pressure cuff to ensure accuracy and to notify the ADON, the Director of Nursing (DON), or the on-call physician of the low blood pressure. An interview on 10/20/25 at 3:58 PM with the DON and Administrator explained she would have expected the Staff D to reassess resident #1 blood pressure on 9/16/25 to ensure accuracy using a manual blood	F0684		

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F0684 SS = D	Continued from page 3 pressure cuff and to notify the ADON, the Director of Nursing (DON), or the on-call physician of low blood pressure.	F0684		