STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165576	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ossian Care Center	114 Fisher Street Ossian, IA 52161

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review the facility failed to obtain informed consent prior to starting psychotropic medications that have black box warnings (the most serious safety warning used by the Food and Drug Administration (FDA) and requires the healthcare provider to have a comprehensive discussion with the resident about the risks, benefits, and alternatives for use) for 5 of 5 residents reviewed for psychotropic medications (Resident #33, #2, #14, #4, and #3). The facility reported a census of 37 residents. Findings include: 1.Resident #33's 10/23/25 Minimum Data Set (MDS) Assessment documented a Brief Interview for Mental Status (BIMS) score of 9 out of 15 indicating a moderate cognitive loss. The MDS documented Resident #33 did not exhibit any behaviors, hallucinations or delirium and had diagnoses of depression. Resident #33 utilized antidepressant medication. A Medication Review Report signed by the Provide on 11/18/25 listed the following physician ordered medications:a. Bupropion Hydrochloride (HCL) (antidepressant medication) extended release, give 150 Milligrams (MG) by mouth every morning. Order date 1/24/23. b. Paroxetine HCL (antidepressant medication) 40 Milligrams (MG) give 1 tablet by mouth one time a day. Order date 1/24/23.c. Mirtazapine (antidepressant medication) give 30 MG by mouth every day at bedtime. Order date 10/2/24. d. Lorazepam oral concentrate (antianxiety medication) 2 MG/Milliliter (ML), give 0.25 ML by mouth every 4 hours as needed for 6 months; give 0.5 MG by mouth sublingual every 4 hours as needed. Order date 8/1/25. A review of the November, December 2025 and January 2026 Electronic Medication Administration Records (EMAR) revealed Resident #33 consistently received the medications as ordered. During an interview on 1/22/26 at approximately 8:45 AM the Assistant Director of Nursing (ADON) reported she would check with the Director of Nursing (DON) on the medication consent as she was working on getting the medication consents completed yesterday (1/21/26). A review of Resident #33's Miscellaneous Clinical Record showed a Consent for Psychotropic Medication Use reviewed with the family on 1/22/26. During an interview on 1/22/26 at 11:19 AM the ADON explained the facility had been doing psychotropic consent forms for the use of antipsychotic medications only. They had not realized they needed to provide the education for antidepressant/antianxiety medications as well. They completed the education with the family this morning and will be addressing all psychotropic medication use/education with resident/family going forward. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #2's MDS assessment dated [DATE] documented a BIMS score of 5 out of 15, indicating severe cognitive impairment. The MDS included diagnoses of dementia, anxiety, and depression. Resident #2's Medication Administration Record (MAR) revealed the following orders: Lorazepam 0.5 mg every 8 hours as needed for agitation, anxiety, restlessness started on 7/29/25, as well additional orders after 7/29/25 for the medication. Resident #2's MARs documented he received lorazepam in July 2025, August 2025, September 2025, October 2025, November 2025, and December 2025. On 1/22/26 at 11:14 AM, the ADON reported the Lorazepam risks and benefits were not done for Resident #2. 3. The MDS assessment dated [DATE] for Resident #14 documented a BIMS of 00 indicating severe cognitive impairment. Review of Resident #14 Clinic Note dated 1/16/26 documented continued orders of psychotropic antidepressant medications sertraline and mirtazapine, but lacked start date. Review of Resident #14 MAR on 1/22/26 documented she received the following psychotropic antidepressant medication sertraline since 9/27/23 and mirtazapine since 12/20/23. Resident #14 Consent for Psychotropic Medication Use consent form, revealed the facility received consent from her resident representative to give her psychotropic antidepressant medication during the survey on 1/21/26 at 12:05 PM 4. The MDS assessment dated [DATE] for Resident #4 documented a BIMS of 12 out of 15, indicating moderate cognitive impairment. Review of Resident #4 Office Visit dated 12/22/25 documented continued order for use of psychotropic antidepressant sertraline, but lacked start date. Review of Resident #4 MAR on 1/22/26 documented he received the following psychotropic antidepressant medication sertraline since 7/18/2025. Resident #4 Consent for Psychotropic Medication Use consent form, revealed the facility received consent from his resident representative to give his psychotropic antidepressant medication during the survey on 1/21/26 at 12:09 PM 5. The MDS assessment dated [DATE] for Resident #3 documented a BIMS of 3 out of 15, indicating severe cognitive impairment. Review of Resident #3 Medication Review Report dated 11/18/25 documented he started on psychotropic antidepressant medication sertraline on 4/10/24 and continued to receive the medication. Resident #3 Consent for Psychotropic Medication Use consent form, revealed the facility received consent from his resident representative to give his psychotropic antidepressant medication during the survey on 1/21/26 at 12:15 PM. Review of the facilities undated policy, Use of Psychotropics Drugs, instructed the following: (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility will obtain signed consents for psychotropic medications that are prescribed at admission or added during residents stay at the facility, and reviewed quarterly.a. Informed consent must be obtained from the resident or the resident's authorized representative before initiating or continuing the use of psychoactive drugs.b. The information about responsible prescribing of the medication should provide the resident or authorized representative with information about the potential benefits, risks, and alternatives to the medication.c. The resident or authorized representative will have the opportunity to ask questions and make an informed decision regarding the use of psychoactive drugs.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, policy review and staff interview the facility failed to notify the physician/provider when holding cardiac medication according to physician ordered vital sign parameters for 1 of 1 residents reviewed for a change in condition (Resident #12). The facility identified a census of 37 residents.Findings include:Resident #12's 12/18/25 Minimum Data Set (MDS) Assessment showed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating a moderate cognitive loss. The MDS listed diagnoses of heart failure, high blood pressure, end stage renal disease, Alzheimer's Disease, Non-Alzheimer's Dementia, and unspecified atrial fibrillation (an irregular heartbeat that makes the heart less efficient at pumping blood and raises the risk of blood clots, stroke and heart failure). A 10/31/25 Clinic Note documented Resident #12 admitted [DATE] to hospital after presenting in the emergency room with heart rates in the 160's. She was hospitalized with atrial fibrillation and received medication adjustment. Resident #12 presented with a heart rate of 40 beats per minute at the clinic appointment. Parameters were added to the Cardizem (heart medication) to notify the provider/hold if the blood pressures were less than 90 systolic or heart rate less than 60. The adult average pulse rate is 60 beats per minute (BMP) to 100 BMP. A Medication Review Report signed by the Provider on 12/12/25 listed to administer Cardizem Extended Release 24 hour 240 Milligrams (MG) tablets, give 480 MG (2 tablets) by mouth one time a day. Hold the medication and notify the healthcare provider if the blood pressure is less than 90 systolic or if the pulse if less than 60 BPM. Medication Task Observation on 1/21/26 at 7:23 AM revealed Staff D, Certified Medication Aide (CMA) completed a blood pressure and pulse check prior to preparing Resident #12's morning medication. Staff D stated Resident #12 had clear parameters set by the physician for the Cardizem medication. Staff D documented Resident #12's blood pressure of 115/94 and pulse 67 in the medication record. Staff D stated Resident #12 tends to run low so they have to watch her closely and hold the heart medication, but it was okay to give today.A 1/21/26 review of Resident #12's Electronic Medication Administration Records (EMARs) revealed the following pulses were outside the physician ordered parameters for the Cardizem medication:a. November (2025) 1, 3, 5, 16, 17, 21, 22, 29.b. December (2025) 3, 9 (pulse 44), 10 (pulse 52), 11, 13 (pulse 50), 20 (pulse 40), 23 (pulse 36), 27, 31 (pulse 53).c. January (2026) 5 (pulse 46), 7 (pulse 48), 11 (pulse 49), 13 (pulse 53), 15, 17 (pulse 43), 18, 19, 20. A 1/21/26 review of the Progress Notes revealed the nurses documented Resident #12's Provider was notified of the Cardizem medication being held on 11/22/25 and 1/20/26. During an interview on 1/22/26 at 7:50 AM the Director of Nursing (DON) reported she and another nurse had reviewed the Resident #12's medical record and did not find that the provider had been notified each time Resident #12's blood pressure or pulse was outside the parameters. The DON stated, We don't have them.Interview completed on 1/22/26 at 8:08 AM the Assistant Director of Nursing (ADON) explained they recently found out management were the only ones that could access the [specific] notification system. The nurses have to notify the provider by facsimile (fax). She would expect if Resident #12's pulse was below the parameters, the nurse would re-assess as sometimes it is the Certified Medication Aides (CMA's) that take the pulse and blood pressure, then the nurse would fax the provider with the information. During an interview on 1/22/26 at approximately 8:59 AM the Provider/Medical Director explained he would expect the nurses to follow the physician order for the parameters on the Cardizem. He further explained most of the time a fax is appropriate, but if the heart rate is falling to 36 or in the 40's he would appreciate a phone call notification. The Change in Condition Policy, undated, provided by the facility directed the facility would promptly notify (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the physician of vital signs that fall outside of the clinical reference ranges in accordance with physician-specified parameters.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review, and staff interviews the facility failed to provide residents and family with adequate notification of financial responsibility when Medicare Part A services were scheduled to be discontinued for 1 of 3 residents reviewed (Resident #42.) The facility reported a census of 37 residents. Findings include:Record review for Resident #42 indicated he received skilled services from 12/17/25 to 1/6/26. Resident #42's Electronic Health Record lacked documentation of the notices being given. On 1/22/26 at 10:49 AM, the Administrator reported Resident #42 did not get a notice of skilled care ending. The Administrator reported she was unaware that the notices were for part A.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, Center for Medicare and Medicaid (CMS) Long-Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User Manual, and staff interview the facility failed to accurately code the use of restraints for 2 of 4 resident reviewed on the Minimum Data Set (MDS) Assessment (Resident #24 and #27). The facility identified a census of 37 residents. Finding include:1.Resident #24's 11/6/25 Minimum Data Set (MDS) Assessment showed a Brief Interview for Mental Status (BIMS) score of 2 out of 15 indicating a severe cognitive loss. Resident #24 did not exhibit upper/lower extremity impairments and was dependent upon staff for chair/bed to chair transfers. The MDS included diagnoses of Alzheimer's Disease with late onset and anxiety. The MDS documented bed rails were utilized daily as a restraint.A Medication Review Report (MRR) signed by the Provider on 12/12/25 listed a physician order for side rails at the head of the bed to aide in bed mobility and repositioning. Original order date 1/12/23. The MRR lacked documentation of restraint orders. Observation on 1/20/26 at 9:51 AM Resident #24 lay in a low bed with an upper half side rail on the right side of the bed and a lower half side rail on the right side of the bed. Resident #24 lay resting with his eyes closed making no attempts to pull at the side rails or get out of bed unassisted. A 1/21/26 review of Resident #24's Risk of Falls related to Dementia and Overestimates Abilities Care Plan revised 8/2025 by the Assistant Director of Nursing (ADON) directed as of 5/14/25 side rails applied both head of bed and foot of the bed as a safety measure. The Activities of Daily Living Self-Care Performance Deficit Care Plan revised 1/12/26 by the ADON directed under Bed Mobility the resident needed 1-2 staff assistance and the resident could use the side rails to help with positioning. A Side Rails assessment dated [DATE] documented Resident #24 with the following:a. Diagnosis of dementia, cognitive impairment or impaired judgement that would affect side rail usage.b. Medical Necessity - resident needs a boundary marker; resident did not need the side rail to assist in positioning, and the legal representative requested the side rail despite the lack of medical necessity. During an interview completed on 1/21/26 at 10:55 AM Staff A, Certified Nursing Assistant (CNA) reported Resident #24 uses the upper and lower rails. The rails are half rails and he can still get out through the center of the bed. He will use the rails to try to stand up in the middle part of the bed. He also uses the upper half rail to assist with turning in bed. He can still get out of bed. The side rails are more of a boundary for him. The rails do not really keep him from doing anything. During an interview on 1/21/26 at 11:00 AM Staff B, CNA explained the resident uses the upper and lower rails on the outer bed. He will use the upper rails to hold onto when they do a check and change for him. Resident #24 can still get through the rails and uses them to stand up which is why he has a fall mat outside of the bed. He hasn't tried to get out of bed for a long time. On 1/21/26 at 12:17 PM, the ADON explained it was the family that signed the side rail consent form stating they wanted the side rails. Resident #24 needed some boundaries and she thought they needed to re-evaluate him. He could still move his feet out of the bed and he could stand up holding onto the rails, but he hadn't tried to do it for a long time. His dementia was advancing and she felt he needed to be reassessed. The ADON voiced it was an MDS coding error, not a restraint issue. She stated she had reviewed the RAI but was still confused on how to code the MDS. She didn't believe the facility had a MDS policy for coding the MDS. She used the RAI to code the MDS. The CMS LTC RAI User's Manual, October 2025, Version 1.20.1, Page 1-4 documented the RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require the assessment accurately reflects the resident's status.Chapter 3 directed if a device is a restraint to code if it is not used, used less than daily or used daily. 2. Resident #27's MDS assessment dated (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] showed a BIMS score of 9/15 indicating a moderate cognitive impairment. Resident #27 did not exhibit upper/lower extremity impairments and required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with chair to bed to chair transfers. The MDS included diagnosis of normal pressure hydrocephalus (a condition where cerebrospinal fluid buildup in the brain which causes difficulty walking, impaired bladder control and cognitive decline). The MDS documented Resident #27 utilized bed rails daily as a restraint. Resident #27's Care Plan revealed family and resident request for repositioning grab bar at the head of the bed, created date 10/23/25. The Care Plan lacked documentation of any restraint use. A 1/12/26 Side Rail Assessment documented Resident #27 utilized a U shaped repositioning bar and lacked documentation the U bar was restraining. Interview on 1/20/2026 at 11:01 AM Resident #27 stated he has the U bar on his bed to assist him with turning and getting in and out of bed. A 1/20/26 review of Resident #27's Medication Review Report signed by the provider on 12/10/25 lacked documentation of a physician order for restraining bed rails. During an interview on 1/21/26 at 12:17 PM the ADON voiced she had also coded Resident #27's MDS incorrectly for restraints. His U bar is to assist him with turning and getting in and out of bed. It did not restrain him.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and Manufacturer's Patient Information review, the facility failed to follow the Manufacturer's Patient Information for proper administration of an insulin pen for 1 of 1 resident sampled (Resident #9). The facility identified a census of 37 residents. Findings include:During Medication Administration Task observation on [DATE] at 7:57 AM Staff C, Licensed Practical Nurse (LPN) reviewed Resident #9's [DATE] Electronic Medication Administration Record (EMAR) which contained a physician order to administer Novolog (insulin aspart) inject 5 units under the skin (subcutaneously) one time a day for diabetes mellitus. Staff C removed Resident #9's insulin pen from the medication cart, placed a needle on the pen without cleaning the rubber stopper with alcohol, dialed the dose knob to 5 units without priming the pen per the Patient Instructions and stated she planned to administer Resident #9's insulin as she walked approximately 10 feet away from the medication cart toward where Resident #9 sat.Staff C was stopped from administering the insulin due to unsafe practice of not priming the pen. Staff C returned to the medication cart. Set the insulin pen to 2 units and primed the insulin pen, then set the dial knob to 5 units. Staff C stated she was ready to give the insulin and walked to within a few feet of Resident #9, when Staff C was stopped a second time from administering the insulin. Staff C failed to check the insulin expiration date. Resident #9's insulin pen's date open label was blank. Staff C check the medication cart for the insulin box but there was no box or bag for the insulin pen. Staff C then pointed to the label on the insulin pen stating the insulin expired in 2027. Staff C was unaware the insulin was only good for 28 days after the pen was opened. Staff C asked the Director of Nursing (DON) what she should do and she was directed to get a new Novolog insulin pen. Staff C obtained a new Novolog insulin pen, failed to clean the hub with alcohol prior to attaching the needle, primed the pen with 2 units, then set the dial knob to 5 units. Staff C administered the 5 units of insulin in Resident #9's upper right arm and failed to complete a 6 second hold during the administration. A [DATE] review of Resident #9's Clinical Record showed a Physician Order to increase the morning dose of Novolog insulin to 5 units signed by the Provider on [DATE].A [DATE] review of Resident #9's Diabetes Mellitus Care Plan directed to administer hypoglycemic (blood sugar lowering) medications as ordered by the physician. Interview completed on [DATE] at 9:36 AM the Assistant Director of Nursing (ADON) reported the nurses would follow the manufacturer directions that come in the box with the insulin pen. The nurse should prime the pen with, she believed 1-2 units of insulin per the manufacturer's directions, then follow the physician order and set the pen to the amount of ordered insulin and give the insulin to the resident. On [DATE] at 9:40 AM the ADON provided the manufacturers Patient Information for the Novolog Injection Pen. She explained the insulin pen did require the pen be set to 2 units to properly prime the pen. The ADON further explained the nurses have a cheat sheet on the medication room fridge that guides them on how long the insulins are good for. Observation on [DATE] at 9:42 AM revealed a small sign labeled Insulin Expiration after Opening hung on the front of the medication room refrigerator. Under (insulin) pens the sign failed to list Novolog (insulin aspart) on the guide. Further observation revealed another small sign hanging on the front of the refrigerator that stated all insulins need an open date and expiration date on both bottle and box when opened. During an interview on [DATE] at 11:15 AM the Director of Nursing (DON) explained she expects the nurses to prime the insulin pen with two units of insulin prior to administering the insulin. The insulin pen is to be dated when opened and if an insulin pen is undated, then the insulin pen should not be used. When queried on insulin pen administration, the DON failed to identify the insulin pen should be held for six seconds to ensure full (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration.During an interview completed on [DATE] at 8:30 AM, the DON reported the facility did not have an insulin pen administration procedure until yesterday ([DATE]) evening when she wrote a new procedure to educate the nurses on. The Manufacturer Patient Information Novolog (insulin aspart) Injection under preparing the Novolog Flex Pen directed to pull off the pen cap and wipe the rubber stopper with an alcohol swab. Under Giving the Air shot before each injection the following was directed:a. Turn the dose selector to 2 units.b. Hold the insulin pen with the needle pointing up. Tap the cartridge gently with a finger a few times to make any air bubbles collect at the top of the cartridge.c. Keep the needle pointing upward, press the push-button all the way in until the dose selector returns to zero. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times. Under Giving the Injection, the Patient Instructions directed to keep the needle in the skin for at least 6 seconds, and keep the push-button pressed all the way in until the needle has been pulled out of the skin to ensure the full dose has been given.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews and facility cleaning checklists, the facility failed to maintain sanitary practices by improperly storing clean dishes and maintaining a clean kitchen. The facility reported a census of 37 residents. Findings include:During initial kitchen observation on 1/20/2026 at 9:10 AM, the following findings were identified: dried food and liquid splatter on the refrigerator in the main kitchen area, convection oven thick dust on top with dried food splatter, sugar and flour storage bins with dried food particle inside and outside of containers, open shelving where dishes are stored dusty and dried dark liquid noted, pans stored on open shelves not inverted, floors throughout kitchen, ceiling vents with thick grease and dust, fan in clean dish area blowing on dishes noted with thick dust, plastic covering for the metal cart which holds the cooking sheets with dried food particles on it, large mixer with dried food particles all over it, and counter top food weigh machine with dried food particles all over it. On 1/20/26 at 9:20 AM Staff E, [NAME] reported the bins on the outside get cleaned weekly and she could not remember the last time they were cleaned on the inside. She noted the container had the bags open but not dated. During follow up on 1/21/26 at 10:10 AM noted areas of concern noted on 1/20/26 remained the same. On 1/21/26 at 11:20 AM the Dietary manager showed the cleaning list for daily, weekly and monthly. She reported she did audits occasionally for cleaning. When showed the areas of concern, she acknowledged they needed to be cleaned. When looked at the cleaning list, staff documented the areas that were cleaned the day prior but when showed the areas and reported they remained the same areas of dirt and dust, she was unsure if they were properly cleaning. She reported the floor is cleaned daily but was unaware they had the same food particles and pieces of food from the day prior. She reported she would have to investigate why it remained the same. Review of the facilities cleaning checklists with a revised date of 12/8/25 documented the areas of concerns noted were to be cleaned daily.