

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Oskaloosa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 605 Highway 432 Oskaloosa, IA 52577	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interview, the facility failed to carry out cardiopulmonary resuscitation(CPR) in accordance with the resident's wishes, and follow the physician's orders for 1 of 1 residents reviewed for cardiopulmonary resuscitation status(Resident #1). The facility failed to correctly identify that Resident #1 desired CPR related to discrepancies in code status listed in multiple locations and a staff member incorrectly reading the resident's chart. Approximately 7 minutes after Resident #1 was last seen alive, the Advanced Registered Nursing Practitioner(ARNP) issued an order to withhold CPR due to the facility staff's delays. The facility staff also lacked knowledge of how to locate the facility's crash cart. This failure resulted in Immediate Jeopardy(IJ) to the health, safety, and security of the resident. The facility reported a census of 76 residents.The State Agency informed the facility of the IJ on [DATE] at 3:35 p.m.The IJ began on [DATE], the day Resident #1 expired. Facility staff removed the Immediate Jeopardy on [DATE] through the following actions:Reeducation of staff regarding the location of resident code statuses and emergency equipment.Placement of a code status book at each nursing station.An audit of resident code statuses.The scope lowered from J to D at the time of the survey after ensuring the facility implemented education and their policy and procedure.Findings included:The Minimum Data Set(MDS) assessment tool, dated [DATE], listed diagnoses for Resident #1 which included heart failure, hemiplegia(one-sided paralysis), and anxiety disorder. The MDSlisted his Brief Interview for Mental Status(BIMS) score as 14 out of 15, indicating intact cognition. Care Plan entries, dated [DATE], directed staff to carry out advance directives per the request of the resident and the family and stated the resident wished to have Staff carry out CPR. The CPR Policy, dated [DATE], stated the resident wished for CPR to be initiated if his heart stopped beating and stated the facility employees would provide basic life support until paramedics arrived. The Physician Order type labeled as advanced directives dated [DATE] directed staff to provide CPR.The [DATE] Medication Administration Record(MAR) listed CPR for the resident's advance directives. The heading on the resident's Electronic Health Record(EHR) listed CPR for the resident's advance directives. A [DATE] Nurses Note stated on [DATE] at approximately 7:45 a.m., Staff A Certified Nursing Assistant(CNA) entered the resident's room followed by Staff C Registered Nurse(RN) and the resident was slumped in his recliner. It appeared the resident was in distress when Staff A and Staff C repositioned him. The resident had an incontinent bowel movement and was diaphoretic(sweating profusely) and unresponsive. Staff C exited the room to obtain assessment tools, summoned the Director of Nursing(DON) to the room, and directed Staff B Licensed Practical Nurse(LPN) to call an ambulance and verify the resident's code status. When the DON arrived, she noted that the resident appeared ashen and diaphoretic and had agonal respirations(abnormal, involuntary gasping for air that indicated a serious medical emergency). The DON checked for a carotid pulse(pulse felt over arteries in the neck) and did not locate</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 165589	Facility ID: 165589 If continuation sheet Page 1 of 10

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>resident's room and he was slumped over in his recliner, almost sliding out. She stated he was very diaphoretic and had had a bowel movement. She stated he was warm but not so warm he was feverish. She stated they were not able to get him up and he was not responsive. She called over the two-way radio for the DON and told Staff B to call 911. She stated they placed him on the ground and stated outside the resident's room, there was not a sticker present so that meant the resident was a DNR. Staff B stood at the doorway and Staff C directed her to double check the Code Status. The DON opened the resident's airway and they were ready to start compressions but Staff B took a long time and had not returned with the verification of the Code Status. Staff C left the room and at the nursing station, Staff B was fumbling and could not find the resident's code status in the paper chart. Staff C told Staff B it was under Advanced Directives and Staff B stated the resident was a DNR. It was at this time that they called the time of death. Staff C stated the aides got him cleaned up and when she opened the resident's EHR to obtain the phone number for the resident's wife, she saw that the resident was a Full Code. Staff C asked Staff B why the EHR stated Full Code when the paper chart said DNR. Staff C stated if she had known he was a Full Code, she would have started CPR. She stated after she spoke with the wife, she thought she should call and cancel the ambulance and she looked at Staff B and stated you called the ambulance, right? Staff B stated oh, I forgot because she tried to find the crash cart. On [DATE] at 11:18 a.m., Staff B stated she and the DON were summoned to the resident's room and he sat in the chair and was purple. She stated she was asked to call 911 and the DON asked her to check the resident's Code Status. She stated she looked for the crash cart and she did not know where it was at first. She stated she and Staff C looked at the resident's code status and stated the resident was a No Code but this was incorrect and they both misread it. She stated they were all flustered. She stated she was working on calling 911 when she retrieved the crash cart. She stated she was flustered and should have called 911. She stated she probably would have initiated CPR(if she had known he was a Full Code). On [DATE] at 12:24 a.m., the DON stated Staff C asked her to meet her in the resident's room. She stated when she arrived, the resident displayed agonal breathing and was diaphoretic and ashen in color. Staff C asked Staff B to check the resident's code status and to call an ambulance. Staff C left the room because they did not have his Code Status and when she found out he was a No Code, she called the time of death. She stated she called Staff F and informed her the resident was a No Code and she gave an order to release the body to the funeral home. She stated Staff C called the family and stated the resident's EHR stated he was a Full Code. She stated she called Staff F back to tell her and it was 7:57 a.m. The DON stated she did not believe if they had initiated CPR it would have changed things but stated they owed it to the family to do so. She stated Staff B stated she forgot to call the ambulance and had gone to look for the crash cart which was not her assignment. She stated Staff B did not know where the crash cart was but they educated her on this during orientation. The DON stated she would have started CPR if she had that information but thought she could trust a fellow nurse. She stated during the incident, the resident's door did not contain the correct sticker to indicate he was a full code due to room changes. On [DATE] at 3:22 p.m., the Administrator stated the Full Code sticker was on the chart but on the wrong side of the resident's door. She stated after the incident they checked all the door stickers and added another book at each nursing station which contained code statuses. On [DATE] at 9:16 a.m Staff G stated she was at the medication cart and someone directed Staff B on the two-way radio to call 911. She stated Staff B was closer to the radio than she was and that she(Staff B) could hear the request. She stated Staff B asked her to locate the crash cart. After she retrieved the crash cart, Staff B told her that the resident was a DNR.</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, clinical record review, and facility policy review, the facility failed to carry out timely assessments and interventions after a resident complained of chest pain for 1 of 3 residents reviewed for a change in condition(Resident #9). The facility reported a census of 76 residents.Findings included:The Minimum Data Set(MDS) assessment tool, dated 6/8/25 listed diagnoses for Resident #9 which included hypertension(high blood pressure), nonrhematic aortic stenosis(a condition where the aortic valve, which controls blood flow from the heart to the body, becomes narrowed or obstructed), and weakness and listed her Brief Interview for Mental Status(BIMS) score as 12 out of 15, indicating moderately impaired cognition. The facility policy Clinical Change in Condition, dated 6/2015, directed staff to assess the resident's status when there was a change in condition and to contact the provider. Care Plan entries, dated 6/23/25, stated the resident had altered cardiovascular status related to high blood pressure, a history of cerebrovascular accidents(strokes), and aortic stenosis and stated the resident would be free from complications of cardiac problems through the review date. The Care Plan directed staff to assess for chest pain with every interaction and to enforce the need to call for assistance when the pain started. An 8/5/25 10:13 a.m. Nurses Note, written by Staff B Licensed Practical Nurse(LPN), stated the resident did not appear to have shortness of breath or wheezing, her appetite was good, and (staff) would continue to monitor.An 8/5/25 12:31 p.m. Orders-Administration Note, written by Staff B, stated the resident received 2 puffs of an albuterol(a medication which helped with breathing)inhaler for shortness of breath after dinner and after ambulation. An 8/5/25 1:51 p.m. Nurses Note, written by Staff B, stated the resident slept since dinner time but stated she was short of breath after ambulation. The resident received her albuterol inhaler and her vitals were: temperature 98.1, pulse 93, respiration 16, blood pressure 106/63, oxygen saturation 96%. The resident rested in a recliner and (staff) would continue to monitor. The resident had a good appetite at meals today. The August 2025 Documentation Survey Report v2 report documented on 8/5/25 the resident ate 10% of her breakfast and lunch. A 2:02 p.m. Orders-Administration Note, written by Staff B, stated the resident's albuterol inhaler was effective. The August 2025 Medication Administration Record(MAR) lacked documentation that staff administered acetaminophen(a non-narcotic pain reliever) to the resident on 8/5/25. The facility lacked further assessments of the resident on 8/5/25 between 2:02 p.m. and 6:56 p.m. and lacked documentation of an update given to the provider. An 8/5/25 6:56 p.m. Nurses Note, written by Staff H LPN, stated staff reported the resident was not acting like herself. The Certified Nursing Assistants(CNA's) reported the resident had marked lethargy(a state of feeling tired, sluggish, and lacking energy) for the majority of the day and this increased as the day progressed. The resident did not eat, drink, or void today and did not wake up to take medications this afternoon/evening. The CNAs stated the resident complained of chest pain. The resident was difficult to arouse and responded only to a sternal rub but then immediately closed her eyes again with no further response. Her blood pressure was 168/82. The facility received on order to send the resident to the emergency room for evaluation and treatment. An 8/6/25 2:20 p.m. Nurses Note stated ER Staff reported the resident admitted for abnormal labs which included high troponin(a protein found in the heart muscle which is elevated when there was heart damage). A hospital Emergency Department Provider Note, dated 8/5/25, stated the resident complained of left-sided chest pain and her left chest wall was tender.A Hospital Discharge summary, dated [DATE], stated the resident admitted on [DATE] with chest discomfort and staff felt the resident suffered a myocardial infarction (heart attack). The resident received medications including aspirin and Clopidogrel(a medication used to prevent blood</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>clots) to treat the condition. On 9/10/25 at 9:53 a.m. Staff F Advanced Registered Nurse Practitioner (ARNP) stated there was a situation with Resident #9 when Staff B worked when she needed sent out and more assessment was needed. During a follow-up interview on 9/11/25 at 8:47 a.m., Staff F, ARNP stated Resident #9 had a significant cardiac history but after she moved back to the dementia unit she was fairly stable. She stated she was in the facility (the day the resident subsequently went to the hospital) and Staff B was the resident's nurse. Staff F stated while she was at the facility, she received no updates from Staff B regarding Resident #9. She stated she left the facility for the day and Staff H from the night shift called her and said she wasn't herself. She advised Staff H to send the resident to the emergency room and she had an elevated troponin. Staff F stated after her hospitalization, she was sent to a Hospice house. Staff F found out later that the resident had expressed chest pain throughout the afternoon but Staff B dismissed this. On 9/16/25 at 12:28 p.m., Staff I CNA stated on the day the resident went to the hospital she just sat there and did not eat normally. She stated the resident complained of chest pain and pointed to her chest and said it felt heavy. Staff I stated she told Staff B this between 2:00 p.m. and 3:00 p.m. Staff I stated Staff B came back to the unit and told the resident she just needed to sit down and that she was fine. Staff I stated she told Staff B that the resident was not normally like this. She stated Staff B left the facility at 6:00 p.m. and Staff H LPN took over. Staff I stated as soon as Staff H arrived in the resident's unit, she called 911 and an ambulance subsequently arrived. Staff I stated the resident had a heart attack. On 9/16/25 at 1:00 p.m., Staff K CNA stated the day the resident went to the hospital, she was pale, lethargic, and coughed. She reported this to Staff B between 7:30 a.m. and 8:00 a.m. and Staff B stated the resident was fine and gave her an inhaler about an hour later. Staff K stated Staff B did not complete vitals until almost 2:00 p.m. She did come back and administer the resident's medications and inhalers and stated the resident was fine but did not complete vitals until around 2:00 p.m. She stated the resident was very different from her baseline and was lethargic and not herself. On 9/16/25 at 2:17 p.m., Staff B stated she remembered the resident had chest pain and she took her vitals and they were normal. She stated she monitored the resident but couldn't remember if she called the provider. She stated she gave her Tylenol and told the staff to keep an eye on her while she passed medications in the other hallways. Staff B stated the resident seemed the same to her as other days. Staff B then stated that she didn't think the resident had chest pain but had chest discomfort. Staff B stated she gave her acetaminophen and she was better. When queried as to whether she thought she should have notified the provider, Staff B did not answer. On 9/16/25 at 3:22 p.m., via phone, Staff J CNA stated she transferred to the resident's unit at 2:00 p.m. on the day in question. She stated the resident seemed really off, wasn't very active, and was not responding. She stated she and other staff told Staff B multiple times that she wasn't answering questions. She stated around 6:00 p.m., she and Staff I tried to get the resident up but could not. She then went to the nursing station where Staff B was giving Staff H report and told them that the resident was not getting up and had not moved or said anything and this was uncharacteristic. Staff J stated when she said this to Staff B and Staff H, Staff B snapped at her and said she had not gotten to that in report yet. Staff J stated after Staff B's shift was over and she left, Staff H came and assessed the resident. At that time, the resident did not respond until after staff gave her a sternal rub. Staff H called the ambulance and the resident admitted to the hospital. On 9/16/25 at 4:18 p.m. via phone, Staff H LPN stated she worked nights on the day in question. When she received report from Staff B, one of the aides stated that Resident #9 wasn't doing great and Staff B snapped at the aide and told her she hadn't gotten to that yet. When Staff B did get to Resident #9, she reported that the aides</p> <p>(continued on next page)</p>		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	said she was super tired but that she was fine and was just playing possum. Staff H stated that Staff B acted like it was no big deal and did not report to her that the resident had chest pain. After Staff B left, staff reported to her that she needed to come and look at the resident. Staff H stated normally the resident was talkative, busy and pacing but at this point she was not herself and extremely lethargic. She stated the resident was slumped over and did not respond much. She had to carry out a sternal rub and the resident opened her eyes but closed them again. She stated she called Staff F and they sent her to the hospital for evaluation. On 9/17/25 at 10:03 a.m., the Director of Nursing (DON) stated if a resident complained of chest pain, staff should carry out an assessment and notify the provider. She stated if a resident had chest pain, they could not rule out that it was a cardiac event. She stated when she heard about the situation with Staff B and Resident #9, she was upset. She stated Staff L was the DON at the time of the incident. On 9/17/25 at 4:00 p.m., via phone, Staff L stated she was not in the building at the time of the situation with Resident #9 but stated staff came to her the next day. Staff reported to her that they told Staff B the resident had chest pain but she just told the resident to sit down. Staff L stated the aides should have reported this to her if the nurse did not listen. Staff L stated Staff B should have notified the provider and had her sent out for evaluation.		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>Based on personnel file review, the facility in-service attendance calendar, and staff interview, the facility failed to implement training for multiple topics for 6 of 6 staff reviewed (Staff B, M, N, O, P, Q). The facility reported a census of 76 residents. Findings included: An Employee Face Sheet listed the hire date for Staff B Licensed Practical Nurse(LPN) as 1/8/25. The facility's Hired List By Date listed the following hire dates: Staff O Certified Nursing Assistant(CNA) 4/16/25 Staff P CNA 7/16/25 Staff Q CNA 8/28/25 The facility lacked documentation that new hires Staff B, Staff O, Staff P and Staff Q completed training in Quality Assurance and Performance Improvement (QAPI), compliance and ethics, and infection control upon hire and lacked documentation that non-new hires Staff M CNA and Staff N CNA completed training in QAPI and compliance and ethics on an annual basis. An undated, untitled facility document stated the facility training program was for all departments including new hires and existing staff. The facility Inservice Attendance calendar listed infection control as a topic but did not include QAPI or compliance and ethics. On 9/17/25 at 12:41 p.m., the DON stated she did not see any additional education in the staff's files and stated they would work to building their training program.</p>		

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<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>Based on personnel file review, the facility in-service attendance calendar, and staff interview, the facility failed to ensure staff completed training in Quality Assurance and Performance Improvement(QAPI) for 6 of 6 staff reviewed(Staff B,M, N, O, P, Q). The facility reported a census of 76 residents.Findings included: An Employee Face Sheet listed the hire date for Staff B Licensed Practical Nurse(LPN) as 1/8/25. The facility's Hired List By Date listed the following hire dates:Staff O Certified Nursing Assistant(CNA) 4/16/25Staff P CNA 7/16/25Staff Q CNA 8/28/25The facility lacked documentation that new hires Staff B, Staff O, Staff P and Staff Q and non-new hires Staff M and Staff N completed training in Quality Assurance and Performance Improvement(QAPI) upon hire/annually. An undated, untitled facility document stated the facility training program was for all departments including new hires and existing staff. The facility Inservice Attendance calendar did not list QAPI as a training topic.On 9/17/25 at 12:41 p.m., the DON stated she did not see any additional education in the staff's files and stated they would work to building their training program.</p>

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<p>F 0945</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program.</p> <p>Based on personnel file review, the facility in-service attendance calendar, and staff interview, the facility failed to ensure staff completed training in infection control for 4 of 6 staff reviewed (Staff B, O, P, Q). The facility reported a census of 76 residents. Findings included: An Employee Face Sheet listed the hire date for Staff B Licensed Practical Nurse (LPN) as 1/8/25. The facility's Hired List By Date listed the following hire dates: Staff O Certified Nursing Assistant (CNA) 4/16/25 Staff P CNA 7/16/25 Staff Q CNA 8/28/25 The facility lacked documentation that new hires Staff B, Staff O, Staff P and Staff Q completed training in infection control. An undated, untitled facility document stated the facility training program was for all departments including new hires and existing staff. The facility Inservice Attendance calendar listed infection control as a training topic. On 9/17/25 at 12:41 p.m., the DON stated she did not see any additional education in the staff's files and stated they would work to building their training program.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Oskaloosa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 605 Highway 432 Oskaloosa, IA 52577	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0946</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide training in compliance and ethics.</p> <p>Based on personnel file review, the facility in-service attendance calendar, and staff interview, the facility failed to ensure staff completed training in compliance and ethics for 6 of 6 staff reviewed(Staff B, M, N, O, P, Q). The facility reported a census of 76 residents. Findings included: An Employee Face Sheet listed the hire date for Staff B Licensed Practical Nurse(LPN) as 1/8/25. The facility's Hired List By Date listed the following hire dates: Staff O Certified Nursing Assistant(CNA) 4/16/25 Staff P CNA 7/16/25 Staff Q CNA 8/28/25 The facility lacked documentation that new hires Staff B, Staff O, Staff P and Staff Q and non-new hires Staff M and Staff N completed training in compliance and ethics upon hire/annually. An undated, untitled facility document stated the facility training program was for all departments including new hires and existing staff. The facility Inservice Attendance calendar did not list compliance and ethics as a training topic. On 9/17/25 at 12:41 p.m., the DON stated she did not see any additional education in the staff's files and stated they would work to building their training program.</p>