STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165185	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Red Oak Rehab and Care Center	1600 Summit Street Red Oak, IA 51566

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review the facility failed to provide sufficient notice of discharge for 1 of 3 residents (Resident #2) reviewed. The facility failed to ensure proper discharge planning was documented prior to discharge. The facility reported the census was 28. Findings include: Resident #2's Entrance Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was admitted from a short term general hospital.The Discharge Return Not Anticipated MDS assessment dated [DATE] revealed the discharge was unplanned and occurred on 4/29/26 to a short term general hospital. The document disclosed the facility staff completed the cognitive patterns indicating the resident presented with memory problems, severe impairment for daily decision making, and fluctuating inattention and disorganized thinking. The document included the resident had delusions, physical behavioral symptoms directed towards others, verbal behavioral symptoms directed toward others, rejection of care and wandering. The self care and mobility sections coded the resident required partial/moderate assistance with toileting hygiene and lower body dressing, and personal hygiene, oral hygiene and eating with setup, independent with upper body dressing, rolling in bed, ambulation and sitting to/from standing. The MDS Assessment included diagnoses of unspecified dementia, unspecified severity with other behavioral disturbances and restlessness and agitation. The document disclosed the resident took antipsychotic and antianxiety medications. The clinical record's census indicated the resident was admitted on [DATE] at 11:15 AM and discharged against medical advice (AMA) on 4/29/26 at 4:02 PM. Resident #2's Care Plan and Kardex for staff were not developed due to the limited time in the facility.The clinical record's Elopement Evaluation dated 4/28/26 identified the following area:History of elopement or an attempted elopement while at home.Verbally expressed the desire to go home, packed belongings, or stayed near an exit door.The resident wanders.Wandering is a pattern, goal directed (specific destination, going home).Recent admission and is not accepting of the situation. The clinical record's Physician Communication dated 4/28/26 revealed the physician was notified of the resident's elopement risk and need for a WanderGuard with a physician order for a WanderGuard and psychiatric evaluation; order noted by nursing on 4/29/26. The clinical record's Hospital Updates dated 4/27/26 contained the following entries: 4/24/26 at 3:11 PM resident verbalized desire to go home.4/24/26 at 4:23 PM resident ambulated in the hall and demanded to go home. 4/24/26 at 5:00 PM resident ambulated in the hall, steadily grew more anxious about leaving the facility. 4/24/26 at 5:49 PM resident continued to escalate in anxious behaviors stating she would walk out of the facility.4/24/26 at 6:17 PM resident ambulated in the hall and attempted to leave the facility to walk home; being closely monitored by staff at all times. 4/24/26 at 6:46 PM resident continued to ambulate in the hall stating she has rights and wanted to go home. 4/25/26 at 8:27 AM resident growing mildly anxious about going home, demanding staff let her leave and ambulating in the hall, intermittently attempting to find an exit. 4/25/26 at 3:17 PM resident grew more anxious about going home, provided scheduled Seroquel. 4/26/26 at 2:16 PM resident stated wanted to go home and became increasingly agitated. 4/27/26 at 1:00 AM resident was up and in the hallway and confused as to whereabouts.An entry made by the (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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospital's nurse practitioner on 4/24/26 revealed the resident was intermittently agitated and paranoid, believing staff were hiding things from her. The document included the resident had agitation, paranoia but no physical aggression. The document revealed the resident's spouse did not feel safe after the resident had physically assaulted him on 4/22/26.The clinical record's Hospital Discharge summary dated [DATE] revealed the resident had been left home alone and found wandering in the neighborhood, prompting a welfare check and transport to the hospital by the police. The document included the family reported escalating agitation at home, including physically attacking her spouse on 4/22/26. The clinical record's Medication Administration Record (MAR) included the following medications were dispensed:Quetiapine Fumarate Oral Tablet 25 mg, give 2 tablets at bedtime related to unspecified dementia, unspecified severity with other behavior disturbance with a start date of 4/28/26. Buspirone HCl Oral Tablet 10 mg, give 1 tablet two times a day (BID) related to restlessness and agitation with a start date of 4/28/26.Quetiapine Fumarate Oral Tablet 25 mg, 1 tablet BID related to unspecified dementia, unspecified severity with other behavior disturbance with a start date of 4/28/26The clinical record's Progress Notes disclosed the following entries:4/28/26 at 12:30 PM the resident admitted to the facility, independent with self care and mobility.4/28/26 at 2:11 PM the resident was at the nurse's station, very agitated and stated she was going home tonight.4/28/26 at 4:09 PM the resident was attempting to open the front door to go for a walk with a family member; the resident was redirected back down the hallway.4/28/26 at 4:24 PM the resident attempted to find an exit to the outside, trying multiple doors; the resident was upset and agitated.4/28/26 at 1:33 PM the resident's behaviors escalated during the day. The entry included the resident entered into other residents' rooms, demanded to nursing staff that she needed to leave to take care of her children at home, sat by the main door attempted to leave and unable to be redirected; notification to primary care physician (PCP) and fax sent to request PRN Ativan. 4/29/26 at 2:05 PM at 7:00 AM the resident was agitated, confused and combative, wandering into other residents' rooms, and she was in the facility by mistake. With interventions the resident made slapping gestures toward staff. At approximately 9:00 AM the resident attempted entry into other residents' rooms and refused to comply with care. The entry included the resident was exit-seeking, testing all facility doors and with multiple failed redirection attempts the resident became more belligerent and physically threatening. By noon, after further escalation, the DON and social services determined that the resident should leave AMA due to ongoing aggression. Family and law enforcement were contacted regarding the situation. 4/29/26 at 2:15 PM orders received for a WanderGuard and psychiatric evaluation. 4/29/26 at 2:24 PM spoke with PCP nurse, aware of the resident's return to the facility, and gave an update to PCP for a PRN medication for agitation. 4/29/26 at 2:44 PM the resident exhibited signs of anxiety and confusion and with redirection the resident became agitated, raised her voice and struck the staff on the arm with an open hand. Resident began packing belongings, moved towards the entrance, and the resident turned and struck staff on the side with a closed fist. The resident continued to demonstrate confusion, exit-seeking behavior, and intermittent physical aggression. 4/29/26 at 3:20 PM resident once again exited the front entrance into the parking lot. Police notified along with EMS, the resident was eventually loaded into an ambulance and transported to ER. The resident will not be returning to the facility. Granddaughter was notified who stated she is being kicked out of this facility too charge nurse continued to reiterate that d/t her exit seeking another facility would need to be located for her.4/29/26 at 4:02 PM Triage nurse was updated on the resident being transported to the community hospital and the facility was not able to take the resident back. The clinical record's Physician Communication dated 4/29/26 revealed the physician was notified the resident was increasing in agitation and restlessness, actively exit seeking, difficulty in redirecting, frequently stating I am leaving, and entering other residents' rooms without permission; noted during hospital stay that Ativan had been utilized and requested an order for Ativan as needed (PRN). The physician response included an order for stat Nexulti 0.5 mg once a day (QD) and Ativan 0.5 mg orally or injection BID PRN (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for agitation for 3 days. The physician order was signed on 4/29/26 and faxed on 4/30/26.The facility failed to notify the Primary Care Physician (PCP) in a timely manner of the need for medical assistance with the resident's escalating verbal, physical and exit seeking behaviors.The facility failed to notify the Medical Director of the resident's escalating verbal, physical, and exit seeking behaviors. The clinical record's Against Medical Advice (AMA) Discharge of Release of Responsibility Form revealed signatures of the resident, Staff A, Registered Nurse (RN)/previous Director of Nursing (DON), and the Director of Social Services. The facility failed to obtain a written order from the physician regarding the resident's transfer and unplanned discharge from the facility. The facility failed by allowing the resident to sign an AMA document when the resident's competency was in doubt, and contacting emergency services for transfer to the hospital and would not allow the resident to return. On 6/16/26 at 10:42 AM Staff C, Certified Nursing Assistant (CNA)/Certified Medication Aide (CMA) stated she witnessed the resident yelling in the lobby and did see the resident outside of the facility with staff. On 6/16/26 at 2:15 PM the Director of Social Services stated she had visited with the resident at the hospital prior to the admission. The staff acknowledged she had reviewed the medical records. The staff stated when she had spoken with the family there was no indication of previous elopements other than what had happened on the day of the resident's admission to the hospital. The staff stated on the morning of the discharge it was revealed the resident had had a rough night and progressively escalated all day and although would occasionally respond positively to the staff, did in fact physically strike the staff. The staff acknowledged she and the DON had the resident sign an AMA document as she (the resident) did not have a Medical Power of Attorney (POA). The staff stated the resident's family thought they had POA paperwork, but in fact the document was for financial affairs. The Director of Social Services stated she did begin the process of getting Medical POA documents for the family by requesting the PCP to sign a letter of incompetence as the resident couldn't sign the document herself for a POA, and did send this document to the lawyer for the family to continue the process following discharge. The staff stated multiple attempts were made to contact the family without success for the need to send the resident to the hospital and find a different facility. On 6/16/26 at 4:20 PM the Administrator (in person) and Staff A (phone) in an interview discussed the details of Resident #2's admission and discharge. Staff A stated she was on the phone with the PCP's nurse at the time of the resident's transfer to the hospital and would notify the physician of the resident going AMA to the hospital. Staff A stated the resident had fluctuating bouts of agitation with calming when she would talk with staff, but eventually escalated to the point of leaving the facility. The staff stated she did return to the facility one time but did not de-escalate. The phone disconnected and the interview involving the Administrator and Staff A ended.On 6/16/26 at 4:25 PM the Administrator acknowledged she was aware of Resident #2's history of wandering and police involvement. The Administrator stated the Director of Social Services stated the resident was a nice lady pleasantly confused. The Administrator stated all department heads were involved with the admission process. The Administrator admitted she and the DON had the ultimate decision to admit a resident and allowed the resident to be admitted , although she had reservations. On 6/17/26 at 10:40 AM the [NAME] President of Operations for Nebraska and Iowa acknowledged the facility had not documented or obtained orders from the PCP or Medical Director for more rapid assistance in managing the resident's needs/behaviors or transfer to the hospital. The staff stated there was a request for a PRN medication but that intervention had not been implemented prior to discharge. The facility's Discharge (including AMA) and Transfer Policy and Procedure, revised 10/22, revealed the facility would evaluate and determine the level of care needed for each resident prior to the admission to ensure the facility's ability to meet the resident's needs. The document included if a discharge was initiated by the facility with return not anticipated reasons for discharge, the facility attempts to meet the resident needs and the service available at the receiving facility to meet the needs, as well as documentation any danger to the health or safety of the resident or other individuals that failure to transfer or discharge would pose. The policy included if (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a transfer/discharge was initiated by the facility for immediate safety and welfare of a resident physician orders were required stating the reason the transfer or discharge was necessary. The AMA portion of the policy included the family/legal representative should be informed of the risks involved with leaving the facility and the physician should be notified of the intended AMA discharge and be encouraged to talk with the resident and encourage staying at the facility.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review the facility failed to provide a bed hold and notify the Long-Term Care Ombudsman (LTCO) of transfer to a hospital for 2 of 3 residents (Residents #2, #5) reviewed. The facility reported a census of 28 residents. Findings include:1. Resident #2's Discharge Return Not Anticipated Minimal Data Set (MDS) assessment dated [DATE] revealed the discharge was unplanned and occurred on 4/29/26 to a short term general hospital. The clinical record's Census revealed Resident #2 discharged against medical advice (AMA) on 4/29/26 at 4:02 PM .2. Resident #5's Discharge Return Anticipated MDS assessment dated [DATE] revealed the resident had an unplanned discharge on [DATE]. The clinical record's Census revealed Resident #5 transferred to the hospital on 3/6/26 at 7:51 AM, and was discharged on 3/25/26. On 6/17/26 at 9:49 AM the Administrator stated a bed hold had not been completed on Resident #5. The Administrator stated at this time she had not located the LTCO report of notification for 3/26 and 4/26. On 6/17/26 at 10:40 AM the [NAME] President of Operations for Nebraska and Iowa disclosed the facility could neither produce a bed hold for Resident #5 nor LTCO Reports for notification of discharges for 3/26 and 4/26. The staff stated the expectation is that the bed hold document should be completed and notification to the LTCO be completed as required.The facility's Notice of Transfer or Discharge to Ombudsman Policy, revised 3/19, revealed notice to the ombudsman must occur at the same time the notice of discharge was provided to the resident and/or representative or as soon as practicable. The document included during emergency transfers a copy of the facility's bed-hold notice must be provided to the resident and resident representatives. The notice of emergency transfers should also be sent to the ombudsman, but may be included on a monthly basis.

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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 clinical record review, observations, staff interviews, and policy review the facility failed to represent an accurate assessment of residents' status during the observation period of the Minimum Data Set (MDS) Assessment for 1 of 6 residents (Resident #3) reviewed. The facility reported a census of 28 residents.Findings include: The MDS assessment dated [DATE] for Resident #3 identified a Brief Interview for Mental Status (BIMS) score of 3/15 indicating severe cognitive impairment. The document coded the resident required partial/moderate assistance for sitting to/from stand, transfers to/from a chair and ambulation up to 150'.Resident #3's Care Plan revised 4/16/26 revealed a focus with alteration in activities of daily living (ADLs) (revised 3/31/23) with staff interventions of independence with transfers and ambulation with a wheeled walker (revised 7/17/24). A focus area identified an ADL self care performance deficit (revised 7/24/24) with interventions of transfers independent with use of a walker (11/19/24).The Kardex printed 6/16/26 revealed the resident was able to transfer himself independently with the use of a walker. The document included the resident was able to get himself in bed and make position changes. The document disclosed the resident was independent with transfers and ambulation with a wheeled walker. Observed on 6/15/26 at 1:05 PM Resident #3 seated in his recliner in his bedroom.Observed on 6/15/26 at 2:45 PM Resident #3 ambulating in his room using a 4 wheeled walker (4WW).Observed on 6/16/26 at 9:00 AM Resident #3 participating in a group activity.Observed on 6/16/26 at 11:40 AM Resident #3 walking to the dining room using a 4WW independently.On 6/16/26 at 10:27 AM Staff B, Certified Nursing Assistant (CNA) stated the resident may require cues to use a walker, but is independent with ambulation. The staff stated the resident is able to bend over or get down and pick something up from the floor and return to standing. On 6/16/26 at 10:42 AM Staff C, CNA/Certified Medication Aide (CMA) stated the resident was independent with walking around, and transfers - including walking to the dining room. On 6/16/26 at 10:55 AM Staff D, CNA/CMA, stated Resident #3 can get down on the floor to look for something and is able to walk in the halls using his 4WW independently.On 6/16/26 at 11:05 AM Staff E, CNA, stated the resident was independent with the use of a 4WW for mobility.On 6/16/26 at 11:18 AM Staff F, CNA/CMA, stated Resident #3 for the most part was independent with mobility, transition movements (sitting to/from lying). The staff stated the resident was independent to walk around the facility with a walker. The facility failed to code the MDS Assessment accurately regarding Resident #3's mobility. On 6/17/26 at 9:49 AM the Administrator stated the facility's corporate representative was assisting with the MDS Assessment. The Administrator stated there were frequent conversations with the staff. The Administrator expected the MDS Assessments to be correct. On 6/17/26 at 10:00 AM the [NAME] President of Operations for Nebraska and Iowa expected the MDS coding to accurately reflect what the residents' levels of care/assistance were. The facility's MDS Accuracy, Automation, and Validation Process Policy, revised 3/19, revealed the MDS Item Sets were to be completed accurately, and during each step of the process they would be screened for accuracy and validation.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff interviews, and policy review the facility failed to revise Care Plans for 2 of 3 residents (Residents #1, #4) reviewed. The facility failed to update the Care Plans with the residents' change in status and fall interventions. The facility reported a census of 28 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The document coded the resident was independent with toileting, dressing, grooming/hygiene, ambulation, transfers and bed mobility. The document provided the resident had a bed alarm that was used daily. The Care Plan revised 1/3/26 identified Resident #1 had functional performance deficits with staff interventions of dressing independent/1 person physical assistance (6/4/25), toilet use limited assist/no setup or physical help (6/4/25), walk in corridor independent/2 person physical assist (9/10/25) and walk in room - independent/setup help only (6/4/25). A focus area identified limited physical mobility related to weakness (revised 6/10/25) with staff interventions for ambulation with standby assistance (SBA) with 1 staff (revised 1/3/26). The Care Plan documented a focus area of the resident had an actual fall with no injury (revised 12/18/25) with interventions of bed/chair alarm in use (12/22/25), continue intervention on the at-risk plan (12/18/25), do not leave unsupervised on the toilet (12/23/25), and the resident instructed to use the call light for assistance with transfers to the toilet and ambulation (12/18/25). The Kardex printed 6/16/26 revealed the resident was weight bearing, SBA for ambulation with 1 staff, resident self transfers. Do not leave the toilet unsupervised, use a call light for transfers to the toilet and ambulation.The facility's document Physician Communication dated 1/4/26 revealed the resident sustained an unwitnessed fall in her bedroom. The facility's document Physician Communication dated 1/30/26 revealed the resident sustained an unwitnessed fall in her bedroom.The facility's document Physician Communication dated 2/14/26 revealed the resident sustained an unwitnessed fall leaving her bathroom. The facility's document Consultation Report dated 5/7/26 with orthopedic provider disclosed physician order for weight bear as tolerated with walker, did not need assistance and to follow up as needed. The facility's document Physician Communication dated 5/7/26 revealed the orthopedic physician indicated the resident could be up as tolerated with walker and does not need assistance. Request to discontinue the alarms to bed/chair or leave bed at night. The document included the physician order to discontinue alarm for chair, OK to leave bed alarm at hour of sleep (HS) for risk of falls, and resident to use her walker at all times. On 6/15/26 at 1:36 PM observed the resident ambulating independently in her room. On 6/15/26 at 7:45 AM observed Resident #1 up in her room when the breakfast tray was delivered. On 6/16/26 at 10:27 AM Staff B, Certified Nursing Assistant (CNA) stated staff can look at the resident's Care Plan or electronic documentation system to determine assistance needs. The staff stated Resident #1 was very independent and did not need assistance.On 6/16/26 at 10:42 AM Staff C, CNA/Certified Medication Aide (CMA) stated staff gained knowledge about a resident's level of care from other staff, the Care Plan and 24 hour report. The staff stated Resident #1 only has a bed alarm following a new physician order; the resident previously had 2 alarms. The staff stated the alarm was to notify staff when the resident was getting up in the morning. The staff stated the resident was independent with self care and ambulation. On 6/16/26 at 10:55 AM Staff D, CNA/CMA, stated information on a resident's needs comes from other staff members, therapy, the Care Plan and/or the Kardex. The staff stated Resident #1 was independent with mobility and self care. The staff stated the resident did have a bed alarm.On 6/16/26 at 11:05 AM Staff E, CNA, stated she obtained information on residents from other staff. The staff stated Resident #1 was very independent with self care and mobility. The staff stated they (staff) do not need to assist the resident with anything unless she requests assistance. The staff stated they had (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stopped the intervention of waiting for the resident outside the bathroom a few weeks prior when the doctor said she could get up on her own. Staff E stated the resident no longer has a chair alarm, only the bed alarm. On 6/16/26 at 11:18 AM Staff F, CNA/CMA, stated the Kardex, the Communication Book, Care Plans and shift to shift reports provide information on the residents' needs. The staff stated Resident #1 was mostly independent and staff did not need to wait outside of her bathroom door. The staff stated the resident will use the call light and request assistance when needed. The facility failed to update the Resident #1's Care Plan to reflect new fall interventions following the falls on 1/4/26, 1/30/26, and 2/14/26. The facility failed to update the Care Plan following the removal of interventions and increased levels of independence. 2. Resident #4's MDS assessment dated [DATE] revealed the staff completed the cognitive assessment with identification of memory problems for short term and long term memory, and severe impairment for cognitive skills for daily decision making. The document coded the resident required total assistance for all self care activities, sitting to/from lying with supervision/touching assistance, and transfers/ambulation up to 150' with supervision/touching assistance. The assessment included diagnoses of Non-Alzheimer's Dementia, seizure disorder or epilepsy and autism. The Care Plan, revised 3/28/26, identified a risk for falls (revised 1/1/24) with an intervention of the bed in a low position, and flat disc light by her hip when in bed (7/2/24). A focus area identified the resident had an actual fall related to poor balance, shuffling gait, and cognition issues (revised 12/28/24) with interventions for the bed in low position (7/2/24), direct resident away from items within facility that may pose fall risk for resident (entry rug, furniture in commons area, medication carts) (11/19/24), disc call light in reach while in bed (7/2/24), ensure resident's room is free of clutter and obstacles (2/12/25), entry rug changed (3/28/26), monitor resident while walking in congested areas (revised 7/10/24), offer w/c when having balance issues (12/5/24), and skid strips next to bed (8/25/25),The Kardex, printed 6/15/26, revealed the resident independently transfers self in and out of bed. The resident was able to reposition herself in bed with no assistance. Fall/Safety Interventions: bed in low position, flat disc light by hip when in bed, disc call light in reach while in bed, skid strips next to bed.Observed on 6/15/26 at 12:55 PM Resident #4 lying in bed with the bed positioned at the lowest position, flat disc call light on the nightstand (not within reach), and no skid strips present at the bedside.Observed on 6/15/26 at 1:55 PM Resident # 4 sleeping in a low bed and the call light on the nightstand.Observed on 6/15/26 at 2:49 PM Resident #4 sleeping in a low bed and the call light on the nightstand. Observed on 6/16/26 at 8:00 AM Resident #4 lying in a low bed and the call light at the head of the bed. Observed on 6/16/26 at 11:33 AM Resident #4 lying in a low bed and the call light at the head of the bed. Observed on 6/16/26 at 11:58 AM Resident #4 walking out of the dining room. Staff C approached the resident and offered her 2 activities with the resident choosing to go back to bed. The resident proceeded to walk independently back to her room, get into bed, roll around, and cover herself up.On 6/16/26 at 10:27 AM Staff B stated Resident #4 is able to get into and out of bed and ambulate by herself.On 6/16/26 at 10:42 AM Staff C stated Resident #4 was independent with all mobility, including getting into and out of a low bed. The staff stated if the resident was having difficulty getting up from the bed, she would scoot on her bottom to the hallway to look for help. On 6/16/26 at 10:55 AM Staff D stated Resident #4 was independent with mobility. The staff stated if she appears tired the staff will use a wheelchair (w/c). The staff stated the resident did not know how to use a call light due to cognitive impairment. The staff stated the resident did not understand cause and effect. On 6/16/26 at 11:05 AM Staff E stated Resident #4 could get up and down by herself most of the time. The staff stated occasionally staff will provide guidance for the resident to ensure she reached the appropriate destination - going to the dining room for a meal. The staff stated the resident did not know how to use a call light and it was used more at night.On 6/16/26 at 11:18 AM Staff F stated the resident was very active and would walk herself up and down the halls. The staff stated the bed was lowered to the floor and the resident always had non-skid socks for fall interventions. Staff F stated the resident may move the call light and acknowledged the resident did (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165185	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Red Oak Rehab and Care Center	1600 Summit Street Red Oak, IA 51566

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not know what the purpose of the touch pad call light was. The facility failed to update the resident's Care Plan to reflect current and appropriate fall interventions for Resident #4. On 6/17/26 at 9:49 AM the Administrator acknowledged Resident #1 was independent for all mobility and self care. The Administrator concurred the fall intervention for the resident to use a flat disc call light was not appropriate and the Care Plans needed revision. The Administrator expected the Care Plans match the residents' needs. On 6/17/26 at 10:00 AM the [NAME] President of Operations for Nebraska and Iowa confirmed the Care Plans were not consistent with the residents' current levels of care. The staff expected the Care Plans to be current with the residents' needs. The facility's Care Planning Policy, revised 3/19, revealed Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur. The document included that the interventions must meet the individual's needs and requires active problem solving, and creative thinking to obtain the individual resident goals.