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	09/25/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, resident interview, clinical record review, facility policy review, and staff interviews the facility failed to re-evaluate the use of the motorized wheelchair quarterly to protect residents from accidents and injuries for 1 of 3 residents (Resident #1) reviewed. The facility reported a census of 30 residents. Findings include:Review of the Minimum Data Set (MDS) for Resident #1 dated 8/15/25 documented an admission date of 3/2/23 and a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documented diagnoses of hemiplegia (a medical condition that causes paralysis or weakness on one side of the body) following cerebral infarction affecting left non-domical side, heart failure, atrial fibrillation, anemia (a condition where the body does not have enough healthy red blood cells to carry oxygen throughout the body), diabetes mellitus, respiratory failure, visual hallucinations, and nausea without vomiting. The MDS revealed the resident required a total dependence on staff to complete transfers and used a wheelchair for mobility. An observation of Resident #1 on 9/22/25 at 1:17 pm revealed the resident left the room to attend an outdoor activity. He was using a motorized wheelchair. He was leaning towards the left side heavily. The back of the chair wasn't tall enough to support his back and only extended to about half the height of his spine. A staff member noted in the hallway, stopped Resident #1 and offered to reposition him to bring him up to the center of the chair but he declined. In an interview with Resident #1 on 9/24/25 at 4:00 pm he stated he tended to lean to the left side in his wheelchair due to his stroke and that the facility's staff always seemed worried about it but he was not concerned about it. He stated that he was utilizing the motorized wheelchair for mobility and also used it outside of the facility for doctor's appointments. He stated that the facility maintenance staff assisted him with some minor adjustments when he needed any help with it. Resident's #1 roommate reported a user manual for the wheelchair was in a closet and at that time it was located in one of the drawers then taken to the administrator's office. A review of the Electronic Health Care (EHR) document titled Care Plan revised on 8/29/25 revealed Resident #1 had a history of hypoglycemia (low blood sugar) related to disease process and interventions directed staff to monitor, document, and report signs and symptoms of hypoglycemia: sweating, tremor, increased heart rate, confusion, slurred speech, lack of coordination, and staggering gait. The Care Plan also documented a focus area of limited physical mobility revised on 5/12/23 and interventions were to provide supportive care, assistance with mobility as needed and to document assistance as needed. A review of the EHR Progress Notes for Resident #1 documented the following entries of altered cognition: On 7/26/25 at 12:00 pm: Resident appears more confused than normal. He thought he was out farming earlier this shift. Urine cloudy with foul odor. Fazed out for urinary analysis. On 8/16/25 at 5:49 pm: Resident at dinner table stating that there were moving bugs in his lettuce salad as he continued to eat the salad. After looking at his salad it was noted by the nurse and other staff including kitchen manager that it was cabbage and not bugs.On 8/17/25 at 10:00 am: Resident sitting up in wheelchair with a nail file and picking at his dentures. He stated that he was trying to get the metal out of his denture. Upon looking at his dentures there appears to be no metal visible. Explained to resident but continued to pick at denture. Resident also stated that he had rubber bands in his food. On 8/30/25 at 12:35 pm: At 11:35 am nurse (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	called down to the resident room. The resident was not acting like himself. He had woken up and drove his power chair under the sink. The resident was leaning in his chair more than normal. Pupils equal, hand grasps equal, smile normal, speech is clear. The resident was complaining of neck pain after falling asleep in his power chair. The resident was given Tylenol for the neck pain. He stated that he did not sleep well last night. The resident roommate stated that he had been talking in his sleep a lot and was restless. The resident was able to take himself to the dining room in his power chair. The resident was having difficulty holding him to put back into his shirt pocket. Resident was able to feed self lunch without assistance. The resident was able to drive the power chair back to his room.A review of the EHR documented the following regarding his wheelchair:On 7/30/25 at 4:04 pm: Called NuMotion and spoke with a representative about the sensitivity of the motorized wheelchair. She verified that the wheelchair was delivered on 7/21/25 and that all other communication will have to go through the care coordinator. Left voicemail with facility number as call back. On 8/6/25 at 9:05 pm Skin/Wound Note Late Entry: Resident has bruising on his right arm. The bruise on the posterior arm is 9x5.5 cm in size. The bruise on the posterior lateral aspect of the right arm is 8x3 cm in size. The resident stated that he was attempting to reach into his cabinet and got his arm caught under the arm of his wheelchair. On 9/5/25 at 3:23 am: 4.5x 4 cm bruise found on the right posterior forearm which is dark purple in color. Resident denies pain/tenderness. Doctor notified.In an interview with the Administrator on 9/25/25 at 10:14 am, she confirmed her expectation was that the facility would perform a safety assessment on a resident with an electric wheelchair prior to using it and the Care Plan would need to be updated. In an interview with the Regional Clinical Coordinator on 9/25/25 at 9:45 am, he confirmed there was an expectation that a safety assessment would be performed for a resident that would be operating an electric wheelchair prior to operating it and he would provide a facility policy regarding an electric wheelchair use by a resident in the facility. In an interview on 9/25/2025 at 8:55 am with the Occupational Therapy (OT) department supervisor, she stated she had knowledge of Resident #1 delivery of the motorized wheelchair in July as she was informed by the NuMotion company they had the electric wheelchair and would be delivering to the facility on a specific date. She also stated she took the next step notifying the facility MDS coordinator of the delivery date. She confirmed that she had knowledge that the toggle controller was too quick when the resident was initially operating the wheelchair and confirmed there was no follow-up completed or in-person assessment completed by the OT department. She stated she was under assumption NuMotion delivery company would be completing a safety assessment. She acknowledged that the OT department had to request an order from a physician to assess the resident for safety once the motorized wheelchair arrived and it was not completed, therefore, the resident was not on their workload to be evaluated. She took further action to contact the NuMotion company and they were able to complete the assessment of the motorized wheelchair toggle controller and adjust it. In an interview with the Director Of Nursing on 9/25/25 at 9:47 am she stated that she did not double check if the Care Plan reflected Resident #1 use of the electric wheelchair and she relied on the MDS Coordinator to add the information to the MDS. She stated she would expect the information to be entered into the EHR by the MDS Coordinator and there was no follow-up in place on her behalf to further monitor if the MDS Coordinator completed the necessary documentation. The DON also stated to her knowledge, there was no special wheelchair safety assessment to be completed for a resident who newly obtained a motorized wheelchair. The DON also stated she felt that the motorized wheelchair safety assessment would be handled by the Occupational Therapy Department and that the NuMotion company that delivered the motorized wheelchair would also complete a safety assessment for Resident #1. She also reported she had knowledge of Resident #1 not capable of driving the motorized wheelchair only 1 time and he was not allowed to further operate the wheelchair until NuMotion came in and readjusted the drive switch sensor. A facility provided policy titled Motorized Wheelchair and Scooter Policy dated September, 2019 documented: The purpose of this policy and procedure is to protect:1. the safety of residents using motorized wheelchairs or (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scooters;2. the safety of other residents, employees and visitors; and3. the facility property from damageA resident has the right and privilege of using a motorized wheelchair or scooter within this facility and on its grounds, if he/she meets eligibility requirements and complieswith all policies and procedures of facility pertaining to motorized wheelchairs and scooters. The purchase and maintenance cost of motorized wheelchairs and scooters arethe responsibility of the resident and/or the resident's family.1. Eligibility requirements for use of a motorized wheelchair or scooter:a. The resident must have, maintain and demonstrate the physical and cognitive ability to safely operate the motorized wheelchair or scooter. Withoutlimitation, this includes the ability to: Grip hand controls and pull the brake lever as needed. Steer around obstacles. Judge distances needed for braking and steering while driving forward and back. Shift the resident's body weight as necessary for going around corners. Concentrate on both driving and the environment around the resident. React quickly in emergencies. Sit for long periods of time and get on and off without assistance. Use patience while in busy or congested areas. Remember safety procedures. Have awareness of the resident's surroundings and where the resident lives. See all obstacles both in front of and coming in from the side (peripheral vision).2. Facility's rules pertaining to the use of motorized wheelchairs or Scooters:a. Only the resident may operate such resident's motorized wheelchair or scooter.Letting another use the motorized wheelchair or scooter, giving rides or pulling something is not allowed.b. Operators must maintain complete control of their own motorized wheelchair or scooter at all times. They must operate their motorized wheelchair orscooter so as not to endanger themselves, other residents, staff, visitors, or Facility property.c. Operators must maintain safe speeds when in use within the Community or on its grounds. Safe speeds are defined as no faster than the average walkingspeed of the other residents in the building. The governor shall be set to a speed limit as determined by Facility.d. The On/Off switch must be turned off when not driving. Example: during transfers, at meals, activities, social events, religious services, etc.e. Operators must, at all times, yield to people/pedestrians and appropriately to other wheelchairs or scooters similar to the rules that apply when driving a car.f. Operators must avoid contact with fixed and moveable objects at all times.This includes people, walls, furniture, rails, tables, doorways, etc.g. Residents may not come within 12 inches of another person walking, in a wheelchair, or in another motorized wheelchair or scooter.h. Residents must be in an upright position at all times.3. Observing the resident's use of the motorized wheelchair or scooter:a. All staff will observe the resident for competent and safe practices and report any variances to the DON or ADON.b. If a resident does not comply with Facility's rules, policies and procedures regarding motorized wheelchairs and scooters, the DON or ADON will determine if a warning or revocation is necessary.c. Facility's interdisciplinary team will re-evaluate the physical and cognitive ability of each resident using a motorized wheelchair or scooter quarterly, or more frequently if deemed necessary. The interdisciplinary team will make recommendations regarding continued use or discontinuing use of the motorized wheelchair or scooter. Results are to be documented and saved in the resident's medical record and/or care plan.4. Facility response to the unsafe use, non-adherence to policy and observation of motorized wheelchair or scooter privileges:a. Facility reserves the right to immediately prohibit a resident's use of the motorized wheelchair or scooter if the resident is a danger to himself/herself or others and/or if substantial property damage has occurred.b. The final decision regarding the resident's use of a motorized wheelchair or scooter at all times rests exclusively with Facility's Administrator, with the advice of the interdisciplinary team. In the absence of the above named, the Director of Nursing or ADON may temporarily prohibit the use of and remove the motorized wheelchair or scooter based on the safety and well-being of residents, staff, or damage to Facility property until an appropriate evaluation can be made.A facility provided policy titled Resident Incident Report Policy revised March, 2019 documented:PROCEDURE1. A Resident Incident Report is completely filled out on all incidents (an incident is defined as anything out of the ordinary, unusual happening i.e.:skin tear, falls, family concerns, allegation of abuse or neglect, altercation between residents, etc.).a. ***IF IN DOUBT---COMPLETE INCIDENT REPORT. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, family interview, staff interviews, and policy review the facility failed to maintain medical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented for 2 of 13 residents (Residents #4 and #6). The facility failed to completely fill out the Medication Administration Record (MAR) - Treatment Administration Record (TAR) for the residents. The facility had a census of 30. Findings include: 1. Resident #4's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status of 14/15 indicating normal cognition. The document provided the resident had diagnoses of Non-Alzheimer's Dementia, anxiety, depression, and chronic obstructive pulmonary disease (COPD) and took medications that included antipsychotics and antidepressants. The resident required oxygen. The resident's Care Plan dated 9/23/25 contained a focus area of shortness of breath related to COPD. Interventions for staff included use of oxygen. The document further contained focus areas with specific target behaviors identified with interventions of non-pharmacological interventions and documentation requirements. The document failed to identify skin integrity concerns for the resident's ears related to the use of the nasal cannula. The Clinical Physician Orders printed 9/25/25 revealed the following orders: Apply Vaseline to bilateral ears where oxygen tubing is rubbing three times a day (TID) for ear breakdown from oxygen tubing related to COPD dated 8/26/25 and revised 9/23/25. Remedy Specialized Protect with zinc oxide paste to buttocks, cleanse area with soap and water prior to application four times a day (QID) for skin integrity with start date of 7/23/25. Document suicidal ideation, anger outbursts and document behavior every shift with start date of 11/29/23. Resident #4's MAR - TAR 9/25 revealed lack of documentation for application of Vaseline for bilateral ears on the following dates/times: 9/5/25 5:00 AM9/14/25 5:00 AM 9/15/25 5:00 AM 9/17/25 5:00 AM 9/18/25 5:00 AM9/19/25 5:00 AM9/21/25 9:00 PMThe MAR - TAR 9/25 lacked documentation for treatment with the Remedy Specialized Protect on 9/21/25 at 9:00 PM and documentation for suicidal ideation, anger outbursts and behavior on 9/21/25 at 6:00 PM. On 9/23/25 at 10:40 AM the Director of Nursing (DON) stated Resident #4 was likely refusing the 5:00 AM treatment as she did not like to get up in the morning and did not like to be bothered. The staff further stated the resident had a history of refusing treatments and care. The staff did acknowledge if the resident was refusing it should be documented as such instead of left blank. 2. Resident #6's MDS dated [DATE] revealed the BIMS was completed by staff with the resident presenting with moderately impaired cognitive skills for daily living, but some short term and long term memory abilities. The document provided the resident utilized a wander elopement alarm daily. The resident's diagnoses included Non-Alzheimer's Dementia, epilepsy, autistic disorder and intermittent explosive disorder. The document provided the resident took antipsychotic, antianxiety, antidepressant, opioid and anticonvulsant medications. The resident's Care Plan dated 9/10/25 provided a focus area of an elopement risk revised 9/10/25 with non-pharmacological interventions dated 8/27/25 and a wander alert in place revised 1/6/25. An additional focus area related to antipsychotic medication dated 10/22/24 contained interventions that included medications, non-pharmacological interventions, and identification of behaviors. The Clinical Physician Orders printed 9/25/25 revealed the following:Push fluids - ice cream, Jell-O, soup, shakes, popsicles, chocolate milk etcetera every shift for dehydration with a start date of 3/25/25.BEHAVIORS - MONITOR for any during shift: 1. Pinching, 2. clawing, 3. Increased pacing DOCUMENT N if monitored and none of the above observed. Y if monitored and any of the above was observed, select chart OTHER/SEE NOTES and ENTER FINDINGS IN PROGRESS NOTE. INTERVENTIONS. 1. redirect 2. offer drink 3.music therapy. d/t behavior related to anxiety/agitation. Codes: 1. Behavior occurred y/n 2. Which behavior observed 3. Intervention 4. Result 5. Frequency BID for health maintenance with a start date of 10/22/24.Check wander guard every shift to ensure in (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	place and to check for function BID for safety with a start date of 7/2/24. Resident #6's MAR - TAR 9/25 lacked documentation on 9/21/25 for behaviors at 8:00 PM, checking of wander guard at 8:00 PM, and pushing of fluids at 6:00 PM. On 9/23/25 at 10:40 AM the DON stated with review of the MAR -TAR 9/25 for Resident #4 and #6 she was unsure of what happened on the evening of 9/21/25, but overall it looked like things fell apart. The DON stated she expected staff to complete documentation. On 9/23/25 at 4:00 PM Staff A, Chief Nursing Executive, acknowledged lack of documentation would lead one to believe the treatments were not completed.On 9/24/25 at 1:30 PM the DON stated she put a notice up at the nurse's station that all areas on the MAR - TAR are to be green before leaving at the end of a shift. The staff stated Assistant Director of Nursing (ADON) stated on one instance overnight she had done the 5:00 AM treatment for Resident #4 but could not document the treatment as TAR had not opened yet as it was scheduled for 5:00 AM and treatment was done at 4:00 AM and she did not go back and document it. On 9/24/25 at 2:30 PM Staff B, Certified Medication Aide (CMA) stated she did not know of a reason to leave blanks on MAR-TAR. Staff stated if there was an unknown reason or refusal it would be documented as such. Staff stated she would not leave at the end of shift if everything was not green (completed). On 9/24/25 at 3:11 PM Staff C, CMA, stated she could not provide a reason as to why she would not document on the MAR-TAR or leave an empty space. Staff stated she would ask the charge nurse or administrator for assistance if there was something she could not document. On 9/25/25 at 8:00 AM the Administrator expected documentation regarding the MAR - TAR to be better than what they have and not be incomplete. The facility's Documentation System Policy revised 3/19 revealed that all services provided included observations, medications administered and services performed must be documented in the resident's medical record. The document also included entries into the medical record may only be made by licensed personnel in accordance with state and federal laws. Trained Medication Aides (TMAs or CMAs) will observe/monitor residents for side effects of medications and notify the nurses who will document onto MAR and into the resident's permanent record. The policy provided the medical record should be up-to-date at all times reflecting the current status of the resident.