STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Manor	737 North Highway Oakland, IA 51560

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)
F 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect a residents' right to refuse some types of non-requested transfers within the nursing home. (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 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to notify residents or resident representatives of room change decisions, or provide explanation for the changes for 4 of 4 residents reviewed (#19, #17, #8, #1). The facility reported a census of 47 residentsFindings include:1) According to the Minimum Data Set (MDS) dated [DATE], Resident #19 had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive deficit). She required partial assistance with dressing and hygiene and supervision only with walking and transferring. Resident #19 had daily wandering activity. The Care Plan for Resident #19, updated on 5/21/25, showed that she had the potential for eloping and staff were to remind her of the location of her room. The resident had a verbal altercation with another resident while rummaging through the wrong room, staff were to intervene as necessary to protect the rights and safety of others. During an ongoing observation on 7/1/25 at 3:40 PM, Resident #19 wandered throughout the hallways, near the offices and fussed with some boxes that were sitting in the hallway. She rambled about doing her job. She got a little irritated when she was redirected but moved on without incident. According to the census tab in the electronic chart, since 1/18/25, Resident #19 had moved rooms 4 times: 1/18/25, 4/1/25, 6/16/25 and 6/27. The chart lacked documentation that that family had been notified. On 7/7/25 at 11:42 AM, a Family Member (FM) emergency contact, said that the family had not been notified of the room changes and were not invited to care conferences. 2) According to the MDS dated [DATE], Resident #17 had a BIMS score of 3 (severe cognitive deficit.) He was independent with eating, personal hygiene and transfers. His diagnoses included: renal insufficiency, cerebrovascular accident (CVA) anxiety, depression and insomnia. The Care Plan updated on 2/20/25, showed that Resident #17 had anxiety disorder, and would pace the halls and accidently enter other resident rooms. Staff put a sign on the door to help remind him of the location of his room. Staff were to include the resident and or responsible party in his treatment plan, and update them as needed regarding change in condition or treatment plan. The census tab in the electronic chart showed that Resident #17 changed rooms on 1/5/25, and again on 1/10/25. The chart lacked notification of family and lacked explanation for the moves. The following was found in the Nursing Progress Notes:a. On 1/6/25 at 9:01 AM, monitoring due to room move, continues to wander around the facility. b. On 1/6/25 at 9:58 AM, the resident said I'm tired of this when attempting to find his room.c. On 1/12/25 at 3:36 AM, Change in Condition, the resident had been up pacing halls throughout the night. More lost/confused than normal.3) The MDS dated [DATE] for Resident #8, showed that he had a BIMS score of 6 (moderate cognitive deficit.) He required supervision with hygiene, dressing, transfers and walking. The resident did not have wandering behaviors and his diagnoses included obstructive uropathy, heart failure, anxiety and intellectual disabilities. The Care Plan for Resident #8, updated on 5/5/25, showed that he and another resident had a verbal altercation in the hallway. He was at risk for falls, staff were to anticipate and meet his needs and to ensure that the call light was within reach. According to the census tab, Resident #8 was moved on 1/1/25 and 2/10/25. The nursing notes lacked explanation of room change or response or family notification. 4) According to the MDS dated [DATE], Resident #1 had a BIMS score of 10 (moderate cognitive deficits.) He required supervision for hygiene, dressing, eating, transfers and toileting. The resident had a feeding tube and his diagnoses included: cancer, anemia, anxiety, depression and psychotic disorder, The Care Plan updated on 5/21/25, showed that Resident #1 had self-care performance deficits, had hypoxic brain related to cardiac arrest, and impaired cognitive function and thought process. The census tab showed that Resident #1 had room changes on 1/28/25 and 2/5/25. The nursing notes lacked explanation or response to the room changes. On 7/7/25 at 4:50 PM, the Administrator said the Social Worker was not aware of their policy regarding notification and explanation for room changes. She would expect that before room changes, staff would visit with the roommates and resident representatives regarding the plans.According to the facility policy titled: Room/Roommate Change reviewed on 10/7/21, Social Services would complete room/roommate change form, resident/resident representative would be made aware of the Room/Roommate change and change forms would be kept in Social Services Department.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews, Electronic Medical Record (EMR) reviews, and policy review the facility failed to notify the physician and resident representative when a change in medical condition and/or treatment occurred for 4 of 4 residents (Resident #1, Resident #14, Resident #19, Resident #18). The facility failed to notify a resident Power of Attorney (POA) of a positive Covid test, a resident's POA of a fall, a physician of oral and enteral feeding refusals with the resident having continued weight loss, and a resident's POA of a psychotropic medication change. The facility had a census of 47. Findings include:1) The Minimum Data Set (MDS) for Resident #1 dated 4/18/25 revealed the Brief Interview for Mental Status (BIMS) score of 10/15 indicating moderate cognitive deficit. The document revealed diagnoses of cancer, anxiety disorder, depression, psychotic disorder, spinal stenosis, oral phase dysphagia and pharyngeal phase dysphagia. The document revealed that while a resident of the facility and within the last 7 days the resident had a feeding tube (g-tube) and mechanically altered diet. The assessment revealed the resident did not have a 5% weight loss in the past month or 10% in the last 6 months. Resident #1's Care Plan dated 6/4/25 revealed a Focus Area for a nutritional problem related to malignant larynx cancer, oral phase dysphagia, severe dysphagia, receiving nutrition via PEG tube (holding), and receiving mechanically altered texture at meals revised 4/22/25. Interventions for staff to follow included: monitor/record/report to physician as needed signs/symptoms of malnutrition: emaciation, muscle wasting , significant weight loss: 3 pounds in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months initiated on 10/1/24; alternate liquids and solids, strict 1:1 bite to drink ratio, must be cued by staff at all meals to alternate liquids with solids and supervision with all oral intake, initiated on 4/16/25; provide tube feeding as ordered (holding) revised 4/22/25; Registered Dietitian (RD) to make tube feeding rate recommendations as needed (PRN) revised 2/24/25, refusing enteral feeding at night due to feeling full revised 6/4/25. The Medication Administration Record (MAR) - Treatment Administration Record (TAR) 6/25 revealed Resident #1 had an order for enteral feed 3 times/day, give Osmolite 1.5, 1 carton at midnight, 4 AM, and 6 AM with a start date of 4/25/25. The document revealed the resident refused 55 of 80 feedings documented during the month. The facility failed to notify the physician of the numerous enteral feeding refusals during the month. The EMR Fluids Intake for 6/25 revealed Resident #1 refused 22 of 80 opportunities documented. The document disclosed the resident consumed the following fluids during the month: 15 opportunities 480 cc41 opportunities 240 cc 1 opportunity 40 cc 2 opportunities 0 cc The EMR Nutrition Intake for 6/25 revealed Resident #1 refused 21 of 80 opportunities documented. The resident consumed the following oral nutrition during the month:7 opportunities 0-25%4 opportunities 26-50%24 opportunities 51-75%24 opportunities 76-100%The facility failed to notify the physician of the oral refusals of hydration and nutrition. An order on the MAR-TAR 6/25 revealed weekly weight 1 time/day every Wednesday for baseline monitoring, must obtain, must notify MD of refusals initiated 4/9/25. The weights revealed a weight of 129.6# on 6/18/25 and a weight of 124.6# on 6/24/25, a difference of 5#.The facility failed to notify the physician of a 5# weight loss. The EMR Weights Summary revealed Resident #1 on 11/7/24 weighed 150.4# prior to the g-tube placement. The first recorded weight after the g-tube placement on 12/13/24 revealed a weight of 141.4#. The recorded weight on 6/30/25 revealed a weight of 124.6#. The difference from 11/7/24 to 6/30/25 was 25.8# and the difference from 12/13/24 to 6/30/25 was 16.8#. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to notify the physician of the continuous weight loss from November (pre g-tube) to June and/or the weight loss from December (post g-tube) to June weight loss.On 7/2/25 at 12;36 PM Staff B, Registered Nurse, stated a physician should be notified if a resident lost 3# in a day or 5# in a week. On 7/7/25 at 10:57 AM the Assistant Director of Nursing (ADON) with the Administrator and Director of Nursing (DON) present stated the physician should have been notified of the resident's weight loss during the month, as well as the gradual weight loss since 11/24. The DON stated Resident #1 was discussed in the previous week's Risk Meeting (week of 6/30/25) but with the holiday during the week all notifications had not been completed. When asked about the length of time from November to July without notification to the physician, a response was not given. On 7/7/25 at 1:30 PM the Physician stated she had just recently been aware of the resident's weight loss and refusals. 2) Resident #14's MDS dated [DATE] revealed a BIMS score of 13/15 indicating normal cognition. The document included diagnoses of diabetes mellitus, hypertension, hyperlipidemia, Non-Alzheimer's Dementia, personal history of traumatic brain injury, and bipolar disorder. The document revealed the resident had antipsychotic and antidepressant medications, and no gradual dose reduction (GDR) had been attempted.Resident #14's Care Plan dated 5/8/25 revealed a Focus Area of alteration in neurological status revised on 4/17/24 with an Intervention of assessment for effects of psychotropic medications. An additional Focus Area of antipsychotic medications related to behavior management revised on 7/26/24 revealed Interventions for staff of administration of psychotropic medications as ordered with documentation/reporting of any adverse effects. Resident #14's Care Plan dated 5/8/25 revealed a nutritional problem related to Type 2 Diabetes revised on 11/19/24 with an intervention for staff to obtain and monitor lab/diagnostic work as ordered and report results to physician and follow up as indicated. The Consultant Pharmacist Recommendation to Physician revealed a recommendation from 10/2024 for reduction of Quetiapine 150 mg daily or Risperidone 2.5 mg every evening. The physician recommended a reduction of Risperdal to 2 mg at night on 1/2/25 with notation by nursing on 1/3/25. The 1/25 MAR-TAR revealed Risperidone 2 mg by mouth at bedtime related to Schizoaffective Disorder was started on 1/3/25. Review of the EMR Progress Notes revealed there was notification to the Resident #14's POA regarding the medication change. The EMR Clinical Physician Orders identified an order for blood sugar testing 4 times/day related to Type 2 Diabetes Mellitus without Complications and to notify if <60 or >450 and as needed. The MAR-TAR handwritten for 3/25 revealed on 3/2/25 Resident #14 had a blood sugar of 506 at 9:00 PM. The document did not provide any additional order regarding insulin provided as a result of the high blood sugar. The EMR Progress Notes revealed no documentation for physician or family notification on 3/2/25. An entry was noted for 3/4/25 entered on 3/6/25 by the MDS Coordinator for notification to the resident's sister regarding the high blood sugar and notification to the physician. An additional late entry note dated 3/4/25 entered on 3/6/25 by the MDS Coordinator indicated the physician was notified of the high blood sugar and insulin was provided as ordered. The facility failed to document notification to the physician regarding the high blood sugar and orders received for insulin in the Progress Notes and/or the MAR-TAR. On 7/2/25 at 9:25 AM Resident #14's POA stated she was not made aware of the resident's change in psychotropic medications until the resident began having delusions like the family had not seen in many years. The POA additionally stated she was not made aware of the resident's high blood sugar until a few days later. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/2/25 at 12:36 PM Staff B stated notification should be made to the physician if a resident has a blood sugar of 450. On 7/3/25 at 5:30 AM Staff S, Agency LPN, stated if a resident has a blood sugar over 450 the primary care provider (PCP) should be notified. On 7/7/25 at 10:57 AM the ADON stated family notification should occur with any change of condition, increase in pain, increase in blood sugars, psychotropic medication change and weight loss. The facility's Notification of a Change in Condition Policy, reviewed and revised 2/6/25, revealed the Attending Physician and Resident Representative will be notified of a resident's change in condition per Standards of Practice and Federal and/or State Regulations. The document identified change in medical/cognitive status, accident/incident, abnormal laboratory findings, refusal to take prescribed medications as reasons for notification. The document further disclosed documentation in the EMR needed to include the change in condition, notification to the provider and the Resident Representative. 3) According to the MDS dated [DATE], Resident #19 had a BIMS score of 3 (severe cognitive deficit). She required partial assistance with dressing and hygiene and supervision only with walking and transferring. Resident #19 had daily wandering activity. The Care Plan for Resident #19, updated on 5/21/25, showed that she was at risk for contracting Covid-19 due to nursing facility/community living. She was at risk for fatal complications.During an ongoing observation on 7/1/25 at 3:40 PM, Resident #19 wandered throughout the hallways, near the offices and fussed with some boxes that were sitting in the hallway. She rambled about doing her job. She got a little irritated when she was redirected but moved on without incident. On 7/7/25 at 11:42 AM, a Family Member (FM) emergency contact, said that the family had not been invited to care conferences. The FM said that the last time they heard from facility was when there was an automated call telling them how many new Covid positive cases there were in the facility. The FM called the facility to ask if Resident #19 had been one of the positive residents and it was confirmed that she was, and her positive test had been 2-3 days prior.4) The MDS dated [DATE] for Resident #18, showed that he did not have a BIMS assessment because he was rarely/never understood. The resident had severe cognitive impairment, hallucinations and delusions. Resident #18 required supervision only for sit to stand, transfers and walking. The Care Plan closed on 4/15/25, for Resident #18, showed that he was at risk for psychosocial wellbeing deficits, staff were to offer and assist with use of the telephone or computer to maintain contact with family and friends. Staff were directed to increase communication between the resident/family/caregivers about the care and the environment. The resident was at risk for falls, and the Care Plan included more than 25 falls with interventions, but lacked an intervention to notify the family of falls. According to a Hospice Coordination Notes Report, printed on 7/2/25 at 9:01 AM, on 4/5/25 the hospice nurse spoke with the resident's family member and she indicated that the facility had not called her about a fall that happened that morning. The hospice nurse was notified on 4/5/25 at 5:55 AM, that the resident had fallen on his face, and had lacerations on his forehead.A Nursing Note dated 4/5/25 at 6:16 AM, showed that Resident #18 was found on the floor in front of the nurses station, Hospice and the administration was notified. The chart lacked documentation that the family had been contacted. On 7/7/25 at 5:00 PM, the Administrator said that their Covid notification of positive cases was automated with the numbers updated daily. She said that the nurse would have called the family to let them know if their loved one tested positive. She said that even though a resident was on Hospice service, the charge nurse was still responsible for calling the family when there was a change in condition.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, facility investigative file review, and facility policy review. The facility failed to ensure 2 of 3 residents (Resident #31 and #34) were free from abuse. The facility reported a census of 47 residents. Findings include:1. According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 2/21/2025 documented Resident #31 had a Brief Interview of Mental Status (BIMS) score of 4. A BIMS score of 4 suggested she had severe cognitive impairment. The MDS documented she utilized a wheelchair for mobility. Resident #31 required substantial/maximal assistance for person hygiene (including combing her hair). The MDS listed the following diagnoses for Resident #31: hypertensive urgency, pneumonia, non-Alzheimer's dementia, adult failure to thrive, and dysphagia. The Care Plan Focus Area with an initiated date of 8/15/2024 documented Resident #31 has Activities of Daily Living (ADL) self-care deficit. The Care Plan documented she required the assistance of one staff for personal hygiene. Staff were encouraged to praise all efforts at self-care. A second Care Plan Focus Area with an initiation date of 8/15/2024 documented impaired cognitive function/dementia or impaired thought processes. The Care Plan directed staff to provide the resident with a homelike environment, encourage family to bring items from home to decorate her room. A third Care Plan Focus Area with an initiated date of 8/15/2024 documented she had a communication problem.The facility's investigative file included the following summary: Resident #31 is an alert [AGE] year-old female who was admitted to the facility on [DATE] that has short/long term memory impairment with a BIMS of 4. On 2/17/2025 at approximately 1:00 PM Staff P Activities Supervisor/Driver/Certified Nursing Assistant (CNA) reported receiving a snapchat from a coworker on shift. Staff P reported it to the Staff C previous Assistant Director of Nursing (ADON) potential HIPAA violation via snapchat of Resident #31 from Staff D CNA while on shift. Staff C reported to the Director of Nursing (DON) and Administrator. The video contained Staff D and Resident #31 in the dining room talking about the resident's hair; Staff D has placed pigtails on Resident #31. Staff D asked the resident to leave her hair up and Staff D asked Resident #31 if she liked her hair two times. The video had a banner or tag that read she can never hear me or so she acts that way. Upon completion of the investigation, it was determined that the resident involved was unable to give consent to the video and was in direct violation of the facility's social media policy. Staff D was interviewed and she stated she was sharing Resident #31's hair because it was cute. She did not think it was an issue and the video was already taken down, then she apologized. She was released from employment on the same day and sent home. Review of the video revealed a clock in the background that indicated it was right before noon. On the top left corner of the video it had Staff D's name and the name of group it was posted to v.i.p. only. According to the stamp on the video it was posted an hour before facility staff were aware of it. At the beginning of the video a female staff member's face was present, then the video was flipped to face Resident #31. Resident #31 sat in her wheelchair in the dining room, fully clothed, her glasses on and bun like piggy tails on each side of her head. In the background sat three other residents by the door leading to the kitchen. The video had a caption that read She can never hear me or so she acts that way with two emojis: a face with a magnified eye piece on and another face that is laughing with tears coming out of the eyes. The resident is directly in front of the phone. Staff D stated leave your buns on your head. The resident said eh and Staff D stated again to leave your buns on your head and laughed. The resident grabbed her hair and Staff D asked if she liked them. Staff D then zoomed the video in closer to the resident and asked if she liked them as the resident continued to touch her hair. Staff D said yea then stated Resident #31's first name. She said her name a second time and the resident said what, Staff D asked her if she liked her hair and the resident shook her head yes. Staff D told her she looked cute, Resident #31 told her thank you and Staff D informed her she did her hair for her. The resident mouthed something and Staff D asked I did good? The video ended and lasted 44 seconds. On 7/2/2025 at 9:39 AM Staff B Registered Nurse (RN) stated she was working when Staff A CNA came up to her and said she needed to show her something. Staff A pulled out her phone and played the video. It was from Staff C's snapchat. She had Staff A go show Staff C since she was in the building. Staff B stated the video was on Staff D's snapchat story and it sounded like she was making fun of Resident #31 for being hard of hearing. Resident #31 was in the video with space buns in her hair and Staff D kept telling her to leave them alone. Staff B stated she felt like Staff D was degrading Resident #31. The video was recorded as Resident #31 was in the dining room with 2-3 other residents in the background. Staff B added there was a caption on the

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In Staff D's employee file a document was signed and dated by her on 4/22/2022. The document indicated all residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This includes prohibiting nursing facility staff from taking or using photographs or recordings in any manner that would demean or humiliate a resident, and prohibits using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep or distribute photographs and/or recordings on social media or through multimedia messages. The facility provided a document titled Employment Policies and Procedures from the facility's Employee Handbook. In the Social Media section, it states: we recognize the growing importance of social media as an effective tool for sharing ideas and exchanging information. However, the nature of online communication is such that anything that you say or share will be captured instantly and can be transmitted forever without your knowledge or consent. The primary goal of this policy is to ensure that our employees understand and observe certain boundaries regarding the appropriate use of social media where doing so has the potential: 1) do harm to the organization's other employees or residents; or 2) create potential legal risks. Company information should not be shared outside the company. Do not share information about residents or coworkers that would violate our other policies against discrimination, harassment, or hostility, and do not identify coworkers or residents by name or otherwise. Do not post online in the company's name or in a manner that could reasonably be attributed to the company without prior written authorization. Staff will not share information about residents that would violate our other policies against discrimination, harassment, or hostility. Staff will not identify residents by name or otherwise. Staff will not post online in the company's name or in a manner that could reasonably be attributed to the company without prior written authorization. In the Personal Cell Phones, it states: use of personal cell phones or other similar devices while on duty is prohibited. Employees must understand that your first priority is the care and welfare of the residents. Use of personal cell phones or other similar devices while on duty is prohibited, limited to breaks and meal periods. The facility provided a document titled Resident Rights with a last reviewed date of 4/26/2023. The document indicated the facility shall treat residents with kindness, respect, and dignity and ensure resident rights are being followed. The resident/resident representative will be informed on their rights upon admission. The facility provided a document titled Abuse Prevention with a last revised date of 10/21/2022. The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, and staff from agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors and any other individual. The facility provided a form titled Media Release Form documented by signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting. I will be consulted about the use of the photographs or video recording for any purpose other than those listed above. There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed. However, I may revoke this authorization in writing at any time. By signing this release, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational or marketing purposes. Staff indicated this is provided per instance for each resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS for Resident #34, dated 6/25/25, showed that she had a BIMS score of 13 (moderate cognitive deficits). The resident had a serious mental illness and was appointed a legal guardian. Since the onset of mental status, there was no evidence of a change from the baseline. She had disorganized thinking (rambling or irrelevant conversation, unclear of illogical flow of ideas or unpredictable switching from subject to subject) was present continuously. Resident #34 required supervision with dressing, hygiene, ambulation and her diagnoses included: heart failure, Non-Alzheimer's Dementia, depression, bipolar disorder, insomnia and adjustment disorder with mixed anxiety and depressed mood. The Care Plan last revised on 4/13/25 showed that Resident #34 had cognitive impairment, impaired decision making and short-term memory impairment. Staff were to assist with decisions as needed, and to provide cues for activities of daily living. Resident #34 had difficulty understanding directives due to inability to focus, flight of ideas and had difficulty expressing herself. She had a history of potential for sexual behaviors and had a tendency to be manipulative with male residents. According to the Preadmission Screening and Resident Review (PASRR) Level II, assessment dated [DATE], limited information was gathered from the resident because she was confused and her guardian provided information on her behalf. The assessment determined that Resident #34 needed specialized services for her behavioral health and/or developmental condition. She had ongoing severe mental health symptoms and aggressive behaviors, irritability and paranoia. Services were authorized to help redirect and redirect her mind and energy so that she could maintain control of her emotions. Some of her most common symptoms included: irritability, tearfulness, unpredictable behaviors, racing thoughts. These symptoms made it difficult for her to interact with others. The result of mental health issues and memory concerns was that she may have a poor awareness to her needs and did not always appear to be capable of making decisions based on health, safety and best interests. The resident had the support of a guardian as appointed by the District Court. On 7/1/25 at 1:32 PM, when asked if there were any residents in the facility that were having sexual relationships, the Social Worker (SW) said that Resident #34 and male, Resident #14 were having intercourse for a while and this had been approved by the guardian. She was not aware of a specific consent form or documentation of that approval from the guardian. On 7/1/25 at 1:00 PM, Resident #34 was in her room sitting on the bed. When asked if there were any residents that come into her room that she did not want in there, she said that there was one resident that she was friends with but she didn't want him in her room any more because he would take my dollars. The resident said that she liked to sit with him at meals and outside. When asked if she thought this resident wanted to have a more intimate relationship with her, she said well he's on medication and that makes him flat. She then explained that his medications make his penis flat. The resident said that he showed her his penis and that he wanted to try but he was just flat. On 7/7/25 at 9:15 AM, the Director from the company that provided a guardian for Resident #34 said that the person she had as a guardian was no longer with the company. The Director went through the file and Care Plan for Resident #34 and did not see anything regarding a consent or conversations related to her having the capacity to make the decision to have sexual relationships with another resident. On 7/8/25 at 9:51 AM, Staff P, Activities Director said that it was a couple of weeks prior, she was passing out newspapers to the resident when she asked Resident #34 if she wanted anything from the store because she was going shopping. The resident told her that she didn't have anything left because he took it all and she didn't have any dollars left. Staff P said that Resident #14 had been spending a lot of time in the room of Resident #34 but she did not have any first-hand knowledge of a sexual relationship, just what staff talked about. The residents are allowed to keep some money in their rooms, but she thought that Resident #34 would get about $10 a month and have her buy snacks and soda. Staff P said that they had a talk with Resident #14 and the situation had been resolved. Staff P said that Resident #34 usually was not intimidated by other residents but it seemed that Resident #34 handled this situation differently, as if she didn't want to upset Resident #14. Staff P had asked Resident #34 if she had told him to stop coming into her room and the resident responded he just won't.On 7/8/25 at 9:30 AM, Staff Q Licensed Practical Nurse (LPN) said that she became aware of a sexual relationship between Resident #34 and #14 during the time when Resident #34 had hyponatremia and she was more confused. Staff Q said that Resident #34 wanted to have this relationship with him and would talk about it openly. Staff Q said that Resident #14 took advantage of her money and would help himself to the snacks and soda she kept in her room. Staff Q said that the facility staff hadn't been educated or given direction on how to manage the situation between the two residents. There

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Oakland Manor	737 North Highway Oakland, IA 51560

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on employee file review, staff interviews and facility policy review the facility failed to complete additional research for 1 of 3 employees (Staff D CNA) when her background check indicated it required additional research. The facility reported a census of 47 residents. Findings include:Review of Staff D Certified Nursing Assistant (CNA) employee file reviewed the following:-a hired date of 4/22/2022-a Single Contact License and Background Check was completed on 4/27/2022 at 12:01 PM. The background check documented further research was required.Staff D's employee file lacked the Department of Human Services (DHS) release that indicated she would be able or not able to work in the facility following further research in to her criminal history research. During an email correspondence on 7/3/2025 at 11:30 AM the Administrator indicated she was unable to track down Staff D's DHS work letter. On 7/8/2025 at 2:10 PM the Interim Director of Nursing (DON) stated Human Resource (HR) staff completes the background checks. Now that they do not have someone in HR it will be the Administrator completing the background checks. She stated historically if a background check comes back flagged for additional research corporate will get involved. If she is not misspeaking, corporate or the Administrator will fill the additional forms out and decide whether or not that staff member can be hired. This should be done prior to the staff member working in the building and documents should be filed in their employee files. On 7/9/2025 at 9:08 AM the Administrator indicated typically HR runs the background checks but she is their back up if they don't have someone in HR. When a staff member requires more research after their background check has been completed its her understanding they inform the employee they have to get additional information, have them fill out additional paperwork and wait for the results from DHS on whether they are allowed to work or not. These documents are then kept in the employee's file. The facility provided a document titled Abuse Prevention with a last revised date of 10/21/2022. Steps to Prevent, Detect and Report:1) The facility conducts employee background checks and will not knowingly employ any individual who has been convicted of abusing, neglecting, or mistreating individuals or misappropriation of property. 2) The facility will pre-screen all potential new employees and residents for a history of abusive behavior.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility investigative file review, staff interviews and facility policy review the facility failed to report a reportable incident to the State Agency within 2 hours of the alleged incident. The facility reported a census of 47 residents. Findings include:According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 4/17/2025 documented Resident #31 had a Brief Interview of Mental Status (BIMS) score of 4. A BIMS score of 4 suggested she had severe cognitive impairment. The MDS documented she utilized a wheelchair for mobility. Resident #31 required substantial/maximal assistance for person hygiene (including combing her hair). The MDS listed the following diagnoses for Resident #31: hypertensive urgency, pneumonia, non-Alzheimer's dementia, adult failure to thrive, and dysphagia. The Care Plan Focus Area with an initiated date of 8/15/2024 documented Resident #31 has Activities of Daily Living (ADL) self-care deficit. The Care Plan documented she required the assistance of one staff for personal hygiene. Staff were encouraged to praise all efforts at self-care. A second Care Plan Focus Area with an initiation date of 8/15/2024 documented impaired cognitive function/dementia or impaired thought processes. The Care Plan directed staff to provide the resident with a homelike environment, encourage family to bring items from home to decorate her room. A third Care Plan Focus Area with an initiated date of 8/15/2024 documented she had a communication problem.The facility's investigative file included the following summary: Resident #31 is an alert [AGE] year-old female who was admitted to the facility on [DATE] that has short/long term memory impairment with a BIMS of 4. On 2/17/2025 at approximately 1:00 PM Staff P Activities Supervisor/Driver/Certified Nursing Assistant (CNA) reported receiving a snapchat from a coworker on shift. Staff P reported it to the Staff C previous Assistant Director of Nursing (ADON) potential HIPAA violation via snapchat of Resident #31 from Staff D CNA while on shift. Staff C reported to the Director of Nursing (DON) and Administrator. The video contained Staff D and Resident #31 in the dining room talking about the resident's hair; Staff D has placed pigtails on Resident #31. Staff D asked the resident to leave her hair up and Staff D asked Resident #31 if she liked her hair two times. The video had a banner or tag that read she can never hear me or so she acts that way. Upon completion of the investigation, it was determined that the resident involved was unable to give consent to the video and was in direct violation of the facility's social media policy. Staff D was interviewed and she stated she was sharing Resident #31's hair because it was cute. She did not think it was an issue and the video was already taken down, then she apologized. She was released from employment on the same day and sent home. Review of the Online Reports to the State Agency documented the approximate date and time the incident occurred was 2/17/2025 at 1:00 PM. The documented indicated the report status changed from unfiled to file initiated on 2/20/2025 at 7:33 PM. Review of the video revealed a clock in the background that indicated it was right before noon. On the top left corner of the video it had Staff D's name and the name of group it was posted to v.i.p. only. According to the stamp on the video it was posted an hour before facility staff were aware of it. At the beginning of the video a female staff member's face was present, then the video was flipped to face Resident #31. Resident #31 sat in her wheelchair in the dining room, fully clothed, her glasses on and bun like piggy tails on each side of her head. In the background sat three other residents by the door leading to the kitchen. The video had a caption that read She can never hear me or so she acts that way with two emojis: a face with a magnified eye piece on and another face that is laughing with tears coming out of the eyes. The resident is directly in front of the phone. Staff D stated leave your buns on your head. The resident said eh and Staff D stated again to leave your buns on your head and laughed. The resident grabbed her hair and Staff D asked if she liked them. Staff D then zoomed the video in closer to the resident and asked if she liked them as the resident continued to touch her hair. Staff D said yea then stated Resident #31's first name. She said her name a second time and the resident said what, Staff D asked her if she liked her hair and the resident shook her head yes. Staff D told her she looked cute, Resident #31 told her thank you and Staff D informed her she did her hair for her. The resident mouthed something and Staff D asked I did good? The video ended and lasted 44 seconds. On 7/2/2025 at 9:39 AM Staff B Registered Nurse (RN) stated she was working when Staff A CNA came up to her and said she needed to show her something. Staff A pulled out her phone and played the video. It was from Staff C's snapchat. She had Staff A go show Staff C since she was in the building. Staff B stated the video was on Staff D's snapchat story and it sounded like she was making fun of Resident #31 for being hard of hearing. Resident #31 was in the video with space buns in her

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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. Based on observations, staff interviews, clinical record review, and policy review the facility failed to review and revise the Care Plans for 2 of 36 residents reviewed (Resident #1 and Resident #34). The facility failed to revise the Interventions for a resident who received oral and enteral intake, and the Goals and Interventions for 2 residents for intimate relations. The facility reported a census of 47 residents.Findings include: 1. The Minimum Data Set (MDS) for Resident #1 dated 4/18/25 revealed the Brief Interview for Mental Status (BIMS) score of 10/15 indicating moderate cognitive deficit. The document revealed diagnoses of cancer, anxiety disorder, depression, psychotic disorder, spinal stenosis, oral phase dysphagia and pharyngeal phase dysphagia. The document revealed that while a resident of the facility and within the last 7 days the resident had a feeding tube and mechanically altered diet. Resident #1's Care Plan dated 6/4/25 revealed an Activities of Daily Living (ADL) Self Care Performance Focus Area dated 10/17/23 with an intervention for staff that the resident was independent with eating dated 10/27/23. The document contained a focus area of impaired cognitive function/dementia or impaired thought process with a revision of 9/19/24 with an intervention stating the resident was nothing by mouth (NPO) revised on 2/24/25. The Care Plan revealed a focus area for a nutritional problem related to malignant larynx cancer, oral phase dysphagia, severe dysphagia; 12/16/24 severe dysphagia - the resident is NPO, receives nutrition via PEG tube (holding), and receiving mechanically altered texture at meals revised 4/22/25. Interventions for staff to follow included: provide tube feeding as ordered (holding) revised 4/22/25; Registered Dietitian (RD) to make tube feeding rate recommendations as needed (PRN) revised 2/24/25, refusing enteral feeding at night due to feeling full revised 6/4/25. The facility failed to revise the Care Plan to identify Resident #1's current status of use of the g-tube feedings at night, and supervised oral intake. On 7/8/25 at 12:30 PM the Assistant Director of Nursing (ADON)/MDS Coordinator stated the Care Plan should match the resident's needs and current abilities. Staff K, Regional Nurse Consultant (RNC), and Staff L, RNC, concurred the Care Plan should match the resident's needs and Physician Orders.The facility's Comprehensive Person-Centered Care Plan Policy, last reviewed 10/23/19, revealed upon a change in condition the Care Plan will be updated to reflect the risks/occurrences with a problem area, including goals and interventions. 2. The MDS for Resident #34, dated 6/25/25, showed that she had a BIMS score of 13 (moderate cognitive deficits.) The resident had a serious mental illness and was appointed a legal guardian. Since the onset of mental status, there was no evidence of a change from the baseline. She had disorganized thinking (rambling or irrelevant conversation, unclear of illogical flow of ideas or unpredictable switching from subject to subject) was present continuously. Resident #34 required supervision with dressing, hygiene, ambulation and her diagnoses included: heart failure, Non-Alzheimer's Dementia, depression, bipolar disorder, insomnia and adjustment disorder with mixed anxiety and depressed mood. The Care Plan last revised on 4/13/25 showed that Resident #34 had cognitive impairment, impaired decision making and short-term memory impairment. Staff were to assist with decisions as needed, and to provide cues for activities of daily living. Resident #34 had difficulty understanding directives due to inability to focus, flight of ideas and had difficulty expressing herself. She had a history of potential for sexual behaviors and had a tendency to be manipulative with male residents. In the intervention column of the Care Plan, dated 9/4/24, it was noted that the resident was having sexual relationship with another resident, but the document lacked interventions or goals related to this issue. A resolved Care Plan focus dated 9/22/20, showed that Resident #34 had a consensual sexual relationship with a male resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/7/25 at 5:00 PM the Administrator said that she would expect that the goals and interventions related to the sexual relationship between two residents would be included on the Care Plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, interviews, Electronic Medical Record (EMR) reviews, and policy review the facility failed to provide services meeting professional standards for 1 of 36 residents reviewed (Resident #1). The facility failed to enter orders on the Medication Administration Record (MAR) - Treatment Administration Record (TAR) for correct route, complete and document physician orders on the MAR - TAR, and follow physician orders for interventions required during oral intake. The facility had a census of 47. Findings include: The Minimum Data Set (MDS) for Resident #1 dated 4/18/25 revealed the Brief Interview for Mental Status (BIMS) score of 10/15 indicating moderate cognitive deficit. The document revealed diagnoses of cancer, anxiety disorder, depression, psychotic disorder, spinal stenosis, oral phase dysphagia and pharyngeal phase dysphagia. The document revealed that while a resident of the facility and within the last 7 days the resident had a feeding tube and mechanically altered diet. The assessment revealed the resident did not have a 5% weight loss in the past month or 10% in the last 6 months. Resident #1's Care Plan dated 6/4/25 revealed a focus area for a nutritional problem related to malignant larynx cancer, oral phase dysphagia, severe dysphagia, receiving nutrition via PEG tube (holding), and receiving mechanically altered texture at meals revised 4/22/25. Interventions for staff to follow included: monitor/record/report to physician as needed signs/symptoms of malnutrition: emaciation, muscle wasting, significant weight loss: 3 pounds in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months initiated on 10/1/24; alternate liquids and solids, strict 1:1 bite to drink ratio, must be cued by staff at all meals to alternate liquids with solids and supervision with all oral intake, initiated on 4/16/25; provide tube feeding as ordered (holding) revised 4/22/25; Registered Dietitian (RD) to make tube feeding rate recommendations as needed (PRN) revised 2/24/25, refusing enteral feeding at night due to feeling full revised 6/4/25. The hospital Continuum of Care Transfer Report dated 12/12/24 revealed Resident #1 was admitted to the hospital with a planned surgical intervention of C4-C7 anterior cervical discectomy and fusion on 12/2/24; complications during the course of hospital recovery resulted in the placement of a PEG tube on 12/11/24, and recommendation for NPO due to severe pharyngeal dysphagia. The Medication Administration Record (MAR) - Treatment Administration Record (TAR) 12/24 disclosed Cyanocobalamin Tablet 1000 MCG, Folic Acid Tablet, Aspirin 81, Bupropion HCl ER (XL), Cholecalciferol Tablet, and Thiamine HCl 100 mg with start dates of 12/13/24 and to provide by mouth; Apixaban 5 mg, Buprenorphine HCl Midodrine HCl 10 mg, Acetaminophen 500 mg, Cyclobenzaprine HCl 10 mg, and Senna-Docusate Sodium with start dates of 12/12/24 and provide orally. The EMR Progress Note dated 1/9/25 revealed an entry with pharmacy recommendation for medications for G-Tube (NPO) orders. An additional Progress Note dated 1/28/25 revealed pharmacist recommendation to nursing staff was to ensure administration instructions for resident ' s orders to state via G-Tube and not by mouth as resident NPO. The Therapy to Nursing Staff Communication form provided to nursing and dietary from Speech Therapy (ST) dated 4/11/25 and signed by the physician revealed the resident must be cued at meals to alternate liquids with solids, strict 1:1 bite to drink ratio, and supervision with all oral intake. The Medication Administration Record (MAR) - Treatment Administration Record (TAR) 6/25 revealed the resident had an order for a regular diet, pureed texture, thin consistency, alternate liquids and solids, strict 1:1 bite to drink ratio, must be cued by staff at all meals to alternate liquids with solids. Supervision with all oral intake for history of dysphagia. Upon review the 6/25 MAR-TAR document disclosed incomplete data in the following areas:Intake and output every 24 hours total from feeding tube dated 3/13/25 - no data recorded on 6/20/25 6a-6p, 6/22/25 6p-6a.Enteral feed order 3 times a day, Osmolite 1.5 1 carton at midnight, 4 AM, and 6 AM dated 4/25/25 - no data recorded on 6/3/25 for 4 AM. On 7/1/25 at 7:39 AM observed Resident #1 seated at a dining room table and was provided with 2 glasses of cranberry juice. There was no staff seated at the table with the resident.Continuous observation on 7/1/25 at 7:57 AM Staff N, Certified Nurse Assistant (CNA), moved to Resident #1's table, but sat back away from the table and resident. Dietary staff served the resident a plate of eggs. The resident took 4 bites of eggs and the staff walked away from the area. Upon return the resident took a 5th bite of eggs, and took a drink. The resident took 2 bites of eggs, and the staff provided a verbal prompt to take a drink. The resident completed 1 bite to 1 drink ratio. The resident proceeded to complete 3 sequences of 2 bites to 1 drink. The resident completed 3 bites to 1 drink. The resident completed 2 bites to 1 drink. The resident consumed approximately 75% of the eggs. During the observation the staff provided cues only 1 time during the meal. Staff was observed having conversations with other residents and staff in the dining room. On 7/3/25 at 11:50 AM Staff E, Contract Speech Language

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interviews and record review, the facility failed to ensure that residents received baths per preference for 1 of 3 residents reviewed. Resident #32 a paraplegia was unable to sit in the shower chair due to lack of trunk support. Staff were providing bed baths only. The facility reported a census of 47 residents. Findings include:According to Minimum Data Set (MDS) dated [DATE], Resident #32 was admitted to the facility on [DATE] from another nursing home. He had a Brief Interview for Mental Status (BIMS) score of 12 (moderate cognitive deficits.) He was impaired on both sides upper and lower extremities, and had an indwelling urinary catheter. He was totally dependent on staff for hygiene showers, dressing and transfers and used a motorized wheel chair for mobility. The residents' diagnoses included: neurogenic bladder, paraplegia, recurrent dislocation of left hip, pressure ulcer of sacral region, insomnia and adult failure to thrive. The Care Plan dated 5/29/25, showed that Resident #32 had self-care performance deficits. Staff were to offer bathing/showering twice weekly and as necessary. He required staff assistance to turn and reposition in bed and 2-staff assistance with the mechanical lift for transfers.In an observation of cares on 7/1/25 at 10:30 AM, Staff J, Certified Nurse Aid (CNA) and Staff I, CNA, transferred Resident #32 from the bed to a shower bed. The aides were unsure how to adjust the rails on the sides and said that it was the first time they had used the equipment. Staff I said that they had been providing bed baths and the resident responded that he really needed to have a real shower at least once a week. A review of the weekly shower/bath documentation, from his admission on [DATE], until 5/10, the resident had one shower. a. The census tab showed that the resident was in the hospital from 5/12-5/15. b. The shower documentation showed that on 5/17/25 he had a bed bath, on 5/20, the resident refused. c. The census showed that from 5/24-5/28, he was in hospital. d. The shower sheets showed that on 5/31 he had shower no documentation of shower offered from 6/1 until June 14th e. The census showed that he went to the hospital on 6/18-6/24. f. Shower documentation showed that he was not offered a shower from 6/25 through 6/30g. Shower documentation indicated the he refused on 7/5. No documentation that he was offered at another time. On 7/2/25 at 8:00 AM, Staff B, Registered Nurse (RN) said that Resident #32 was just getting bed baths because he didn't have the trunk support to sit in the shower chair. It was just on 7/1 that they found the shower bed in the basement of the facility to use in the shower room. According to facility policy titled: ADL Care Bathing last reviewed on 7/21/22, nursing staff would assist in bathing resident to promote cleanliness and dignity. The charge nurse would be made aware of residents who refused bathing.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, provider interview and policy review, the facility failed to ensure that residents received adequate and timely assessments and interventions for 2 of 12 residents reviewed (Residents #23 and #31). Staff failed to consistently monitor Resident #23 for side effects from psychotropic medications, and failed to complete neurological assessments after Resident #31 had an unwitnessed fall. The facility reported a census of 47 residents. Findings include:1. According to the Minimum Data Set (MDS) dated [DATE], Resident #23 had a Brief Interview of Mental Status (BIMS) score of 11 (moderate cognitive deficits). The resident required supervision with hygiene, dressing, toileting and transfers. Her diagnoses included: anxiety, depression, bipolar disorder, chronic pain disorder, opioid dependence. The high-risk medication included: antipsychotic, antianxiety, antidepressant, and opioids.The Care Plan for Resident #23 updated on 3/20/25, showed that she had a history of behavior problems, staff were to administer medications as ordered, monitor and document side effects and effectiveness. The medications that Resident #23 was prescribed, put her at risk for adverse side effects, staff were to notify the physician of any abnormal findings. The side effects for antipsychotic medications included tardive dyskinesia (TD) (involuntary repetitive muscle movements), Extrapyramidal Symptoms (EPS), shuffling gait, rigid muscles and shaking. Abnormal Involuntary Movement Score (AIMS) is a standard structured assessment for the initial screening and routine monitoring of TD symptoms. The American Psychiatric Association recommends an assessment at least every 6 months in patients at high risk of TD. Retrieved on 7/9/25 at 5:52 AM from: https://www.austedohcp.com/tardive-dyskinesia/screening-diagnosis-and-assessment?According to the census tab, Resident #23 was admitted to the facility on [DATE]. The chart lacked documentation of any AIMS assessments or other routine monitoring tools for TD until 5/30/25. The following was found in the Nursing Progress Notes:a. From 2/24/25 - 3/27/25 the nursing notes lacked documentation of any resident complaint of tremors or shaking. b. On 3/27/25 at 4:37 AM, the resident reported feeling more shaky and thinks it's due to her medications. Nurse educated her on side effects, will continue to monitor. c. On 3/27/25 at 7:40 PM, observed hands were shaking when handed a cup of medicationd. On 4/1/25 at 9:35 AM, behavior observed: resident complained of feeling weak and shaky. Seen numerous times talking in the hallway without assistance. Stating she needs a wheel chair. e. On 4/3/25 at 8:26 PM, the Nurse Practitioner (NP) noted tremors and shakiness, suggested to be behavioralf. On 4/4/25 at 2:26 AM, shaky during medication pass. Head shaking along with hands when taking medication. g. On 4/8/25 at 2:15 PM, attention seeking behavior noted. The resident rolled into office with walker that she feels she needs with no tremors noted. Begins having tremors while she turned into office, gait stead, behavior noted. The nurse explained that if there was new symptoms she needed to let the provider know when she comes to the facility. h. On 5/30/25 at 4:30 PM, AIMS completed, moderate tremor left arm and hand. i. On 6/3/25 at 1:52 AM, new orders regarding tremors from possible medication side effects included neurologist appointment and a decrease in gabapentin. j. On 6/10/25 at 10:53 AM resident stated mouth cannot stop moving and it felt weird, educated on TD. Shaking had increase, noted tremors. Informed NP resident on aripiprazole 10mg with SE of tremors. Asked to complete the AIMS assessment and compare it to previous A Patient Note from the Nurse Practitioner (NP) dated 6/15/25 at 9:00 AM, showed that Resident had an AIMS score of 11. She was noted to have increased tremors in her hands. Staff reported increased movements, concerned primarily in her hands and face. (A positive AIMS examination is a score of 2 in two or more movements or a score of 3 or 4 in a single movement). A hospital report dated 6/29/25 at 7:25 PM, showed a psychiatric evaluation due to suicidal ideation included reference to involuntary tremors, worsening symptoms of depression anxiety and self-harm, concerns for TD. On 7/9/25 at 7:42 AM, Staff O, Nurse Practitioner (NP), said that he would like to see the AIMS assessment completed upon admission when a resident was on a psychotropic medications. He said it should be completed upon admission and at least quarterly. On 7/7 2:24 PM Staff Q, Licensed Practical Nurse (LPN) said that she was not familiar with an AIMS assessment. She thought that the assessment was used to determine behaviors and suicidal ideation. She doesn't remember every seeing one or using one. On 7/7/25, at 2:43 PM, Staff B, Registered Nurse (RN) said that she was not very familiar with the AIMS assessments and the first one she ever did was when Resident #32 had been watching a commercial about TD and asked her if she thought she might have that side effect. Staff B then called the doctor and completed an AIMS. On 7/7/25 at 5:00 PM, Staff K, Nurse Consultant said that in their other

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. According to the quarterly MDS assessment tool with a reference date of 2/21/2025 documented Resident #31 had a BIMS score of 4. A BIMS score of 4 suggested she had severe cognitive impairment. The MDS documented she utilized a wheelchair for mobility. Resident #31 required substantial/maximal assistance for person hygiene (including combing her hair). The MDS listed the following diagnoses for Resident #31: hypertensive urgency, pneumonia, non-Alzheimer's dementia, adult failure to thrive, and dysphagia.The Care Plan Focus Area with an initiated date of 8/15/2024 documented Resident #31 was at risk for falls. The Care Plan encouraged staff to not leave her alone on the toilet/commode, keep walkway free of clutter, lay the resident down for bed after dinner time meal, nonskid strips to be applied to floor in front of toilet/commode and side of bed, and provide a fidget board or take to fidget station when resident is restless and wanting to help staff.The following Progress Note was documented: on 4/22/2025 at 5:44 AM resident had a fall in her bedroom. The Certified Nursing Assistant (CNA) last eyes on her during rounds, she was changed then and went back to sleep. She then decided to get up out of bed to transfer to the commode; she fell while transferring. Neurological checks were restarted. Review of Resident #31's clinical record revealed a neurological evaluation form dated 4/22/2025. The form instructed staff to completed post fall if resident hit their head or had an unwitnessed fall: every 15 minutes for 1 hour, every 30 minutes for 1 hour, every hour for 2 hours, every 2 hours for 8 hours, every 4 hours for 12 hours and every shift for 48 hours. Staff failed to complete the neurological evaluation on 4/22/2025 at 9:30 PM, 4/23/2025 at 1:30 AM, 5:30 AM, 6:00 PM, and 4/25/2025 at 6:00 AM.On 7/8/2025 at 2:10 PM the Interim Director of Nursing (DON) stated neurological assessments should be completed every 15 minutes for 1 hour, every 30 minutes for 1 hours, every hour for 2 hours, every 2 hours for 8 hours, every 4 hours for 12 hours then every shift for 48 hours. Essentially, they are to be completed for 72 hours once they are all done. Resident #31's neurological evaluation form dated on 4/22/2025 was reviewed with her. She acknowledged she could see they were not completed as they should have been.The facility provided a document titled Neurological Evaluation with a last reviewed date of 3/28/2023. The documented a neurological evaluation will be performed by a licensed nurse when a resident's status warrants; suspected head injury, stroke, and/or an unwitnessed fall to identify a change in condition related to a possible head injury or a physician's order. PROCEDURE:General Information-The licensed nurse shall perform a neurological evaluation as followed for a 72-hour timeframe, unless otherwise ordered by the physician. The results will be recorded on the Neurological Evaluation Form. -Every 15 Minutes X1 Hour-Every 30 Minutes X1 Hour-Every 1 Hour X2 Hours-Every 2 Hours X8 Hours-Every 4 Hours X12 Hours-Every Shift X48 HoursInspect Pupil Reaction-Darken roomPerform hand hygiene & apply gloves. Open eyelid with finger, turn on flashlight & observe pupil size and reaction. Repeat steps for the other eye. Determine motor ability; instruct resident to move upper extremities & squeeze nurse's fingers; Document strength bilaterally. Observe if resident obeys commands & pain. Note resident reacts to pain, withdraws, or has no response. Determine sensation in extremities; rub resident's arms at the same time to see if decrease in sensation, numbness and/or tingling in either arm. Have the resident smile; determine if there is facial drooping and document accordingly. During neurological evaluation; compare the right side of the body to the Left side. Additional information shall be recorded in the resident's medical record.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, staff interviews, clinical record review and staff file review, the facility failed to prevent accidents for 1 of 7 residents. Resident #36 slid from her wheelchair while being transported to an appointment in the facility van. The staff failed to ensure that the resident was stabilized by applying the shoulder strap of the seat belt. The facility reported a census of 47 residents. Findings include:According to the Minimum Data Set (MDS) dated [DATE], Resident #36 had a Brief Interview for Mental Status (BIMS) score of 13 (moderate cognitive deficits). She required substantial assistance with dressing, toileting, hygiene, and was totally dependent on staff for transfers. Her diagnoses included: peripheral vascular disease, renal insufficiency, diabetes mellitus, low back pain and unsteadiness on feet. The Care Plan updated on 6/9/25, showed that Resident #36 was at risk for falls and on 5/14/25, she had a fall from the wheelchair, sustained an abrasion to the left knee, treatment and order in place. Weekly treatment documentation would include measurement of each area of skin breakdown, width, length, depth and type of tissue and exudate. According to an Incident Report dated 5/13/25 at 7:30 AM, Resident #36 transferred to an appointment in the facility van and she slid out of her Wheelchair (WC) and onto the pedals of the WC. The resident was not making sense when she returned to the facility, and she had an abrasion to the left knee. All the van drivers were re-educated and demonstrated the proper way to secure residents who were in wheel chairs. A Progressive Discipline Request dated 5/14/25, for Staff M, Transportation Specialist, showed that on 5/13/25, he was driving to an appointment with two residents in the van. Staff M approached a red light too quickly and pressed hard on the brakes. The breaking caused Resident #36 to slide forward in her wheelchair, the cushion slid down onto the top of the foot pedals and her feet were on the floor of the van. Staff M failed to follow safety protocol in the van. The resident only had a lap belt on and not the shoulder strap. Staff M did not notify the residents nurse or take the resident to be evaluated. Staff M failed to report the incident to the administration and the event was reported by the resident. Staff M was terminated from employment on 5/15/25. On 7/7/25 at 3:00 PM, Resident #36 said that Staff M would drive fast in the van and he would stop very quickly. She said that his driving did scare her sometimes because he was careless, but she didn't tell anyone that it made her nervous or afraid. The resident said that she had a lap strap on but not a shoulder strap. Resident #36 said that she slid out of her WC and ended up sitting on the foot pedals. She had a scrape on her left knee. A Skin Observation Tool dated 5/13/25 at 10:00 PM, showed that Resident #36 sustained a left knee abrasion. The document lacked measurements or further description. An Order Audit Report showed that on 5/14/25 at 11:53 AM, staff were directed to apply ski prep to the left knee daily until resolved. On 7/1/25 at 10:30 AM, Resident #32 said that the previous van driver would drive like crazy. He said that he would drive fast, stop and go quickly. The resident said that the driving did not scare him. According to the Minimum Data Set (MDS) dated [DATE], Resident #32 had a Brief Interview for Mental Status (BIMS) score of 12 (moderate cognitive deficits.) The resident was totally dependent on staff for toileting hygiene, showers, dressing and transfers. His diagnoses included: Neurogenic bladder, paraplegia, adult failure to thrive. On 7/7/25 at 3:10 PM, the Maintenance Director (MD) said that the van had room for two, wheelchairs. At the time of the incident with Resident #32, there was just one shoulder strap for the front WC chair. The strap was not working very well, it would get stuck, so he ordered two new straps and those had been installed. On 7/8/25 at 12:32 PM, Staff M said that Resident #32 didn't slide very far, and he got in trouble because he didn't have a nurse assess her right away. He said that he pulled over and assisted the resident back into the wheelchair, then took her appointment. He said that in hindsight, he should have gotten a nurse. He acknowledged that he hadn't used the shoulder strap to secure her in better. Staff M said that he thought he had proper training, it was just that when the light changed it was bad timing and a distance thing so he had to slam on the breaks. When asked if any of the residents ever expressed to him that his driving made them nervous he said that a couple of residents did tell him that he was a fast driver so he tried to keep it down. He said that for some reason, they were in a rush that day. On 7/7/25 at 5:00 PM, the Administrator, Director of Nursing, and Assistant Director of Nursing maintained that they had no knowledge that some residents had concerns about Staff M's driving or that the shoulder straps were not working in van. They said that they would expect that eventually, residents would mention these kinds of concerns in Resident Counsel, or to their Care Partners, (managers assigned to specific residents. They were to check in with them on a regular bases and build trusting relationships) According to

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that they monitored urine output for residents with urinary catheter and were at risk for urinary tract infections for 1 of 3 residents reviewed. (Resident #32.) The facility reported a census of 47 residents. Findings include:According to the Minimum Data Set (MDS) dated [DATE], Resident #32 was admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS) score of 12 (moderate cognitive deficits.) The resident was totally dependent and on staff for toileting hygiene, showers, dressing and transfers. He was always incontinent of bowel, and had a urinary catheter. His diagnoses included: neurogenic bladder, paraplegia and adult failure to thrive. The Care Plan dated 5/2/25, showed that Resident #32 had self-care performance deficit and required staff assistance to turn and reposition in bed. The resident had a suprapubic catheter due to diagnosis of neurogenic bladder. Staff were to monitor for signs and symptoms of urinary tract infection including no output. On 7/1/25 at 10:30 AM, Certified Nurse Aid (CNA) said they monitored urine output on all catheters. The Orders tab in the electronic chart showed an order dated 5/4/25 at 8:30 AM, directing staff to record the amount of output from catheter per shift, monitoring for signs and symptoms of infection every shift for urine output.The hospital report dated 5/3/25 at 10:10 AM showed that Resident #32 had been admitted to the hospital on [DATE] with a primary complaint of septic shock. A review of the Medication and Treatment Administration Records (MAR/TAR) for June showed that on 3 days, the output was collected just once, and from June 24th - 30th the chart lacked any documentation of urine output.The Point of Care (POC) Response History for Foley Output this Shift, in a 30 day look back period, the chart lacked documentation of urine output from 7/1/25 - 7/7/25On 7/7/25 at 5:00 PM, Staff K, Nurse Consultant, said that they don't do output on all catheters, but if there was a physician order or if the resident was high risk, she would expect monitoring of urine output. She said that there was documentation in the tasks. A reference from a nursing textbook, sent on 7/8/25, showed that staff would monitor intake and output as ordered. Monitor for changes in urine output including volume and color. Notify the practitioner of abnormal changes. Empty the bag regularly when it became one-half to two-theirs full to prevent undue traction on the urethra from the weight of urine in the bag.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on electronic medical record (EMR) review, staff interviews, provider interview and policy review the facility failed to develop and implement interventions to stabilize or improve a resident's nutritional status before complications arose for 1 of 1 resident reviewed (Resident #1). The facility failed to monitor enteral and oral intake, respond to continuous weight loss over a 7 month period, and develop an integrated approach to the progression of enteral intake to oral intake. The facility reported a census of 47 residents. Findings include:The Minimum Data Set (MDS) for Resident #1 dated 4/18/25 revealed the Brief Interview for Mental Status (BIMS) score of 10/15 indicating moderate cognitive deficit. The document revealed diagnoses of cancer, anxiety disorder, depression, psychotic disorder, spinal stenosis, oral phase dysphagia, and pharyngeal phase dysphagia. The document revealed that while a resident of the facility and within the last 7 days the resident had a feeding tube and mechanically altered diet. The assessment revealed the resident did not have a 5% weight loss in the past month or 10% in the last 6 months. Resident #1's Care Plan dated 6/4/25 revealed a focus area for a nutritional problem related to malignant larynx cancer, oral phase dysphagia (swallowing disorder), severe dysphagia, receiving nutrition via PEG tube (holding), and receiving mechanically altered texture at meals revised 4/22/25. Interventions for staff to follow included: monitor/record/report to physician as needed signs/symptoms of malnutrition: emaciation, muscle wasting , significant weight loss: 3 pounds in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months initiated on 10/1/24; alternate liquids and solids, strict 1:1 bite to drink ratio, must be cued by staff at all meals to alternate liquids with solids and supervision with all oral intake, initiated on 4/16/25; provide tube feeding as ordered (holding) revised 4/22/25; Registered Dietitian (RD) to make tube feeding rate recommendations as needed (PRN) revised 2/24/25, refusing enteral feeding at night due to feeling full revised 6/4/25. A Care Plan Focus Area of Activities of Daily Living (ADL) performance contained an intervention of independent eating dated 10/27/23. A focus area of impaired cognition with a revision on 9/19/24 revealed an intervention of the resident having nothing by mouth (NPO).The facility failed to integrate Resident #1's oral and enteral intakes into an integrated approach with the entries indicating the tube feedings were being held as updated on 4/22/25 by Staff H, RD, notification to the physician for symptoms of malnutrition, interventions contradicting each other with supervision and strict 1:1 bite drink ratio and indicating the resident was independent in self feeding, and the resident was NPO. The hospital Continuum of Care Transfer Report dated 12/12/24 revealed Resident #1 was admitted to the hospital with a planned surgical intervention of C4-C7 anterior cervical discectomy and fusion on 12/2/24; complications during the course of hospital recovery resulted in the placement of a Percutaneous Endoscopic Gastrostomy (PEG) tube on 12/11/24, and recommendation for NPO due to severe pharyngeal dysphagia. The Fiberoptic Endoscopic Evaluation of Swallowing (FEES) evaluation and report dated 12/26/24 recommended the continuation of NPO, and all nutrition, hydration, and medications continue via the PEG tube. The FEES evaluation and report dated 3/4/25 recommended pureed solids and thin liquids with the Speech Language Pathologist (SLP) only and progression of the diet be determined by the resident, family and medical team. The resident required a 1 bite to 1 drink ratio (1:1) alternation to optimize safety and minimize aspiration risk. The facility document Therapy to Nursing Staff Communication Form dated 3/4/25 revealed Resident #1 to receive thin liquids and pureed trials only with SLP, monitor for signs/symptoms of aspiration, and complete oral care daily. In the EMR Progress Notes an entry on 3/24/25 by the Registered Dietician, (RD) Staff H, revealed the resident's weight was stable at 137.6#, NPO, and received nutrition via PEG tube. The document indicated the resident received 300 cubic centimeters (cc's) Osmolite 1.5 4 times/day (QID) with 150 cc's water (H20) QID which provided 1800 kilocalories (kcals), 76 gram (gm) protein and 1760 cc's fluid or 29 kcal/kilogram (kg), 1.3 g protein/kg and 28 ccs fluid/kg - stable weight indicated needs were met.The facility document Therapy to Nursing Staff Communication Form dated 4/11/25 with the physician signature provided to Nursing and Dietary revealed Resident #1 to receive pureed texture and thin liquids for all meals, required cues at meals for strict 1:1 bite to drink ratio, upright 60 minutes after meals, oral care 2-3 times/day, supervision with all oral intake, and medications crushed in puree. The EMR Progress Note entered by Staff H, RD on 4/24/25 revealed the resident's weight of 134.4# was stable, received regular diet with pureed texture - consuming 25-75% at 2 meals/day - Received 300 cc's Osmolite 1.5 QID with recommendation of changing feeding rate to 80 cc/hour (hr) Osmolite 1.5 with 40 cc/hr H20 x 12 hours overnight - recommended tube feeding would provide 1440 kcals, 60 gm protein and 1248 cc's fluid; recommended rate met 80% of estimated nutritional

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F 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on electronic medical record (EMR) review, resident interview, staff interviews, and policy review the facility failed to provide care and service to an individual with a feeding tube resulting in complication of enteral feeding and medication administration for 1 of 1 residents reviewed (Resident #1). The facility failed to identify the skills and abilities needed of the direct care staff when providing enteral medications to the resident resulting in 4 hospital visits including 3 overnight stays within 4 weeks. The facility reported a census of 47 residents. Findings include: The Minimum Data Set (MDS) for Resident #1 dated 4/18/25 revealed the Brief Interview for Mental Status (BIMS) score of 10/15 indicating moderate cognitive deficit. The document revealed diagnoses of cancer, anxiety disorder, depression, psychotic disorder, spinal stenosis, oral phase dysphagia, and pharyngeal phase dysphagia. The document revealed that while a resident of the facility and within the last 7 days the resident had a feeding tube and mechanically altered diet. The assessment revealed the resident did not have a 5% weight loss in the past month or 10% in the last 6 months. Resident #1's Care Plan dated 6/4/25 revealed a focus area with an alternative nutritional intake via tube feeding initiated on 12/19/24 and resolved on 4/22/25. The interventions for staff included checking tubing placement and gastric contents/residual volume per facility protocol/record (initiated 12/19/24 and resolved 4/22/25), elevate the head of bed 45 degrees during and 30 minutes after tube feed (initiated 12/19/24 and resolved 4/22/25), and monitor/document/report any signs/symptoms of aspiration, tube dislodged, infection, tube dysfunction or malfunction (initiated 12/19/24 and resolved 4/22/25). An additional focus area of nutritional problem area initiated 10/1/24 with a revision on 4/22/25 included 12/16/24 severe dysphagia - resident receives nothing by mouth (NPO), receives nutrition via Percutaneous Endoscopic Gastrostomy (PEG) tube (holding), need for mechanically altered diet. Interventions for this focus area included administer medications as ordered initiated 10/1/24, monitor/record/report to physician as needed signs/symptoms of malnutrition: emaciation, muscle wasting, significant weight loss: 3 pounds in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months initiated on 10/1/24, provide tube feeding as ordered (holding) initiated 12/16/24 and revised 4/22/25, alternate liquids and solids, strict 1:1 bite to drink ratio, must be cued by staff at all meals to alternate liquids with solids and supervision with all oral intake, initiated on 4/16/25, and Registered Dietitian (RD) to make tube feeding rate recommendations as needed (PRN) initiated 12/16/24 and revised 2/24/25.The hospital Continuum of Care Transfer Report dated 12/12/24 revealed Resident #1 was admitted to the hospital with a planned surgical intervention of C4-C7 anterior cervical discectomy and fusion on 12/2/24; complications during the course of hospital recovery resulted in the placement of a PEG tube on 12/11/24, and recommendation for NPO due to severe pharyngeal dysphagia. The Medication Administration Record (MAR) - Treatment Administration Record (TAR) 12/24 revealed orders for flush tube with water with 200 milliliters (ml) 6 hours 4 times a day with an order dated of 12/12/24 and discharge 12/17/24, flush tube with water with 150 milliliters (ml) every 4 hours for flush with an order date of 12/17/24, tube feeding Osmolite 1.5 300 ml every 6 hours via PEG tube 4 times/day with an order date of 12/15/24. Increase water flushes for medications 60 ml every day and night shift with an order date of 12/21/24, check tube placement prior to feeding/medication administration with an order date 12/12/24, intake and output every 24 hour total from feeding tube with an order date of 12/12/24, and a highlighted For Your Information (FYI) resident is NPO, all meds crushed and given in bolus, give per G-tube, 30 ml flush before and after meds, at all times NPO with a start date of 12/12/24. The EMR Progress Note dated 12/12/24 revealed Resident #1 returned to the facility with a PEG tube in place, patent with flushes and the tube feedings infusing at 50 ml per hour, bolus water flushes 200 ml every 6 hours. The EMR Clinical Census reported the following hospitalizations:12/17/24 hospital <3 days with return on 12/19/241/5/25 hospital <3 days with return on 1/6/25.1/8/25 hospital <3 days with return on 1/9/25.The EMR Progress Notes beginning 12/17/24 revealed Resident #1's PEG tube had become clogged and the resident was transferred to the hospital. The resident returned to the facility with the hospital not addressing the clogged tube, and the resident was sent back to the hospital. An entry on 12/18/24 disclosed the resident was being admitted to the hospital for G-Tube replacement. The hospital document After Visit Summary dated 12/18/24 - 12/19/24 revealed the primary diagnosis for admission was Complication of Artificial Opening of Stomach. The hospital document Continuum of Care Transfer Report dated 12/19/24 provided diagnoses for admission Gastrostomy Tube Dysfunction and Feeding Tube Blocked. A Progress Note entry dated 12/19/24 revealed

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	165230	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Manor	737 North Highway Oakland, IA 51560

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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on the previous Centers for Medicare and Medicaid Services (CMS) form 2567 review, staff interviews, and facility policy review the facility failed to ensure they provided a comprehensive, effective Quality Assessment and Performance Improvement (QAPI) program. The facility reported a census of 47 residents. Findings include:A review of the Department of Inspections, Appeals, and Licensing website revealed the facility had repeat deficient practices identified during the annual, revisit surveys and complaint investigations from 12/20/2021 to 12/23/2024. The repeat deficiencies cited include:-12/20/2021 during a complaint investigation: 580 Notification of Changes, 684 Quality of Care, 693 Tube Feeding Management, and 880 Infection Control-3/25/2022 during a revisit survey: 880 Infection Control-6/3/2022 during a recertification and complaint survey: 580 Notification of Changes, 607 Develop/Implement Abuse/Neglect, etc Policies, 689 Accidents and Hazards, 692 Nutrition/Hydration Status Maintenance-8/31/2023 during a recertification survey: 657 Care Plan Timing and Revision, 684 Quality of Care, 693 Tube Feeding Maintenance, 880 Infection Control-4/22/2024 during a compliant investigation: 580 Notification of Changes, 658 Services Provided Meet Professional Standards, 880 Infection Control-11/21/2024 during a recertification survey: 689 Accidents and Hazards, 880 Infection Control-12/23/2024 during a compliant investigation: 880 Infection Control.On 7/9/2025 at 9:08 AM the Administrator stated after they receive the results of a survey, they will immediately start educating staff on all problem areas and ensure interventions are in place. She will hold a mandatory in-service with everyone. Making them aware of what deficiencies were cited, what they can do better and get their input on what they can do to improve. To help ensure the deficiencies are not repeated during future surveys, they will continue to do audits after they have cleared the 2567. The facility provided a document titled QAPI, with a revision date of 1/10/2025. QAPI is the coordinated application of two mutually reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing caregivers in practical and creative problem solving. Procedure:-The QAPI members shall include representatives from all departments in the Interdisciplinary Teams. This also includes seeking input from residents, resident representative, and front line care staff.-Reviews collected data that helps to identify opportunities for improvement in care and processes.-Identify Quality Care and Process Improvement opportunities.-Complete a Process Improvement Plan (PIP), which includes root cause analysis, to create Action Plans for areas identified. The facility provided a document titled QAPI Plan that had the following purpose statement: QAPI takes a structured and proactive approach guiding us to continually improve the way we care for and engage with the people we serve, our co-workers, and our business partners. QAPI helps us strive for excellence in all that we do. Above all, we focus on quality.1.Guiding Principles:-We make QAPI a part of all that we do.-We focus on improving systems and processes. -We us data to monitor, benchmark, and prioritize decision making with the root cause analysis tool.-Our QAPI plan prioritizes opportunities for improvement. We clearly define goals, review them monthly, and update them at least every six months. -We continuously seek input from the people we serve and their families, employees, and business partners to help guide and prioritize our QAPI efforts. -We encourage all employees to identify opportunities for improvement and share ideas for change. -We use the facility's QAPI tools and techniques to make improvements in all departments and all levels of care.-We continue to learn and share information along with best practices-We work together to solve issues and make improvements.2. Scope-All departments and levels of care (service lines) will implement QAPI and use QAPI methods and tools.-QAPI will address quality of life, quality of clinical care and services, safety and resident autonomy and choice. -QAPI will utilize evidence-based practices, data, benchmarks and clinical guidelines to define and measure goals.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, Electronic Health Record (EHR) reviews, staff interviews, and policy reviews the facility failed to implement appropriate hand hygiene and infection control practices to mitigate the spread of pathogens during resident cares for 3 of 3 residents (Resident #33, Resident #1, and Resident #32). The facility failed to maintain appropriate placement of catheter bag placement, utilize hand hygiene, appropriate glove use, and Enhanced Barrier Precautions (EBP). The facility reported a census of 47. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings include:1. The Minimum Data Set (MDS) for Resident #33 dated 7/3/25 in progress revealed a Brief Interview for Mental Status (BIMS) score of 13/15 indicating normal cognitive function. The document revealed diagnoses of Cerebrovascular Accident (CVA)/Transient Ischemic Attacks (TIA), anxiety order, depression, psychotic disorder, Schizophrenia, and Cauda Equina Syndrome. The MDS identified the resident had an indwelling catheter.Resident #33's Care Plan dated 7/2/26 under development revealed a Focus Area with Suprapubic Catheter with a revision on 6/30/25. Observed on 6/30/25 3:16 PM Resident #33's catheter bag lying on the floor while the resident was in bed. On 7/7/25 at 10:57 AM the Assistant Director of Nursing (ADON) with the Administrator present stated a catheter bag should not be lying on the floor. 2. The MDS for Resident #1 dated 4/18/25 revealed the BIMS score of 10/15 indicating moderate cognitive deficit. The document revealed diagnoses of cancer, anxiety disorder, depression, psychotic disorder, spinal stenosis, oral phase dysphagia and pharyngeal phase dysphagia. The document revealed that while a resident of the facility and within the last 7 days the resident had a feeding tube and mechanically altered diet. The assessment revealed the resident did not have a 5% weight loss in the past month or 10% in the last 6 months. Resident #1's Care Plan dated 6/4/25 revealed a focus area related to EBP initiated on 5/30/24. The interventions provided for staff knowledge include completion of enteral tube and wound care required the use of gown and gloves. Observed on 6/30/24 at 11:00 AM Resident #1 had an EBP sign on the door reflecting the personal protective equipment (PPE) needed and when to wear. Continuous observation on 7/1/25 at 9:48 AM Staff E, Registered Nurse (RN), revealed provision of enteral tube flushing and bandage change with Resident #1. A, The staff brought in the supplies for the dressing change, donned gloves. B. The staff removed the bandages from around the gastrostomy tube (g-tube), removed gloves, washed hands and donned new gloves.C. Staff E opened the bandage packages, sprayed the gauze pads, and cleaned around the insertion site. D. The staff removed gloves, donned new gloves and proceeded to spray new gauze and wipe the area. E. The staff obtained a new gauze pad and dried the area. F. Staff E obtained an additional gauze pad, sprayed the gauze, and wiped the resident's tube. G. The staff discovered did not have the correct bandage to complete the dressing change, placed a temporary gauze pad on top, taped it in place, removed the gloves, and left the room to obtain the necessary bandage. H. Staff E re-entered Resident #1's room, opened the packages, donned gloves, placed the bandages, secured in place, dated, removed gloves, and left the room. I. The staff returned to the room with a new graduated cylinder and syringe for flushing Resident #1's tube. J. The staff dated the cylinder, donned gloves, and proceeded to flush the resident's tube with 2 syringes of water. K. Staff E completed the treatment with taping the g-tube in place to prevent getting caught. L. Gloves removed, trash sealed and removed from the room. Staff E demonstrated inconsistent hand hygiene practices with glove removal/application, did not utilize a gown with dressing change, g-tube flushing, did not maintain clean and dirty environments when opening packages, placement and removal of bandages, and non-use of a barrier for bandages during dressing change. In an interview on 7/7/25 at 10:57 AM the Assistant Director of Nursing (ADON) with the Administrator present stated the expectation is for hand hygiene and glove changes to be completed between dirty and clean tasks, the use of a barrier for clean supplies, and EBP during any tasks involving Resident #1's g-tube. The ADON stated EBP consisted of a gown and gloves during personal care and g-tube care. The Administrator concurred with the ADON's statements. The facility's policy Enhanced Barrier Precautions, reviewed 5/15/24, revealed the use of gown and gloves for high-contact resident care activities is indicated when Contact Precautions do not apply for residents with wounds and/or indwelling medical devices regardless of multidrug-resistant organism (MDRO) colonization. The document further revealed a sign should be posted in the resident room with the required personal protective equipment (PPE) including gown and gloves for high contact activities including device care with examples of urinary catheter, enteral tube, dressing transfers, and toileting. The facility's policy Hand Hygiene, reviewed 4/28/22, indicated hand hygiene should be performed before and after applying/removing gloves/PPE, and before/after performing care. The U.S. Department of Health and Human Services Centers for Disease Control and Prevention EBP sign on Resident #1 and Resident #32's doors revealed providers and staff must wear gloves and gown during high contact resident care activities including dressing, bathing, transferring, hygiene, changing briefs or assisting with toileting, and wound care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. According to the MDS dated [DATE], Resident #32 was admitted to the facility on [DATE] from another nursing home. He had a Brief Interview for Mental Status (BIMS) score of 12 (moderate cognitive deficits). He was impaired on both sides upper and lower extremities, and had an indwelling urinary catheter. He was totally dependent on staff for hygiene showers, dressing and transfers and used a motorized wheel chair for mobility. The residents' diagnoses included: neurogenic bladder, paraplegia, recurrent dislocation of left hip, pressure ulcer of sacral region, insomnia and adult failure to thrive. The Care Plan dated 5/29/25, showed that Resident #32 had self-care performance deficits. Staff were to offer bathing/showering twice weekly and as necessary. He required staff assistance to turn and reposition in bed and 2-staff assistance with the mechanical lift for transfers. Staff were to provide Enhanced Barrier Precautions (EBP) related to wounds and indwelling catheter. EBP when transferring and providing hygiene. In an observation on 7/1/25 at 10:30 AM, Staff J, Certified Nurse Aid (CNA) and Staff I, CNA, provided personal incontinence cares for Resident #32. Staff J wiped the resident's gluteal area with disposable wipes while his urinary catheter bag rested on the bed. The resident had a bandage on his bottom. The staff members failed to wear gowns while providing the care and transfer. On 7/7/25 at 5:00 PM, the Administrator said that the CNA should have donned EBP when providing care to Resident #32 due to his catheter and wounds. According to the facility policy titled: Enhanced Barrier Precautions reviewed on 5/15/24 examples of high contact resident care activities required gown and gloves for urinary catheters and wound care.