

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2025
NAME OF PROVIDER OR SUPPLIER Oakland Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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)

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on clinical record review, facility investigative file review, staff interviews and facility policy review the facility failed to timely report an allegation of abuse between 2 residents reviewed (Resident #1 and #2) to the appropriate management staff member. The facility reported a census of 40 residents. Findings include: According to the quarterly Minimum Data Set (MDS) with a reference date of 9/11/2025 documented a Brief Interview of Mental Status (BIMS) score of 10. A BIMS score of 10 suggested mild cognitive impairment. The MDS documented the following diagnoses: dementia, neurogenic bladder, schizophrenia, and post-traumatic stress disorder (PTSD). The Care Plan Focus Area with a revision date of 7/1/2022 documented Resident #1 had impaired cognitive function and impaired thought process due to his diagnoses of dementia and schizophrenia. A Progress Note documented on 9/27/2025 at 1:27 PM: between 11:00 AM and 11:30 AM Resident #1 began to become more agitated while sitting at the smoking doors, yelling out at staff stating let me out of this f***ing place, I want to go back to council bluffs. This nurse and a Certified Nursing Assistant CNA came up to resident, said CNA attempted to push resident in his wheelchair but he grabbed the CNA's hand, ripping off her finger nail. Resident began to laugh, yelling out and continued to talk to himself. By this time resident had pushed himself to the nurses station and began yelling at another resident (Resident #2), the situation escalated, both residents began yelling and cursing at each other in-between dining area and nurse's station. Resident #1 then stood up out of his wheelchair and Resident #2 stood up out of his wheelchair as well. Resident #1 then stepped forward, striking Resident #2 in the face using a closed fist. This nurse and CNA were able to separate these residents prior to any further physical altercations occurring. The facility's investigative file included a document titled Self Report. In the Reporting Information section, the approximate date and time occurred was documented as: 9/27/2025 at 11:30 AM. In the Events section the report status was changed from unfiled to file initiated on 9/29/2025 at 2:39 PM. Review of the Complaint/Incident Investigation Report documented the incident occurred on 9/27/2025 with a submit to the State Agency date of 9/29/2025 at 2:39 PM. On 10/15/2025 at 9:48 AM Staff A Registered Nurse (RN) stated she called the Administrator at 11:37 AM but she did not answer. She then called their Interim Director of Nursing (DON) to report a reportable and needed to know what to do. She was crying stating she quit, so Staff A stated she called the Administrator multiple times but she called her back about 2:50 PM. On 10/15/2025 at 11:54 AM the Administrator stated the day of the incident their Interim DON quit via text message. The charge nurse, Staff A made her aware of the altercation between Resident #1 and Resident #2, earlier in the day. The Administrator acknowledged she did not return the call until about 2:30 PM or so. At that point she knew it was already passed the reporting timeframe. She indicated she was running errands, doing her life so she did not call her back. At that time, she did not know the interim DON had quit. The Administrator stated Staff A did the right thing by calling her right way. She acknowledged it was her fault that it was reported late to the State Agency. The facility provided a document titled Abuse Prevention with a last reviewed date 10/21/2022 documented the facility is committed to protecting the residents from abuse by anyone including other residents. Alleged violations involving abuse are to be reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. If the events that cause the allegation do not involve abuse and do not result in serious bodily injury, are reported immediately but not later than 24 hours after the allegation is made, to the administrator of the facility and to other officials (including State Survey Agency and local law enforcement as required).</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on record review, staff interviews and facility policy review the facility failed to update 2 of 3 resident's care plans (Resident #1 and Resident #2) after they were involved in a resident to resident altercation. The facility reported a census of 40 residents. Findings include: 1) According to the quarterly Minimum Data Set (MDS) with a reference date of 9/11/2025 documented a Brief Interview of Mental Status (BIMS) score of 10. A BIMS score of 10 suggested mild cognitive impairment. The MDS documented the following diagnoses: dementia, neurogenic bladder, schizophrenia, and post-traumatic stress disorder (PTSD). A Progress Note documented on 9/27/2025 at 1:27 PM: between 11:00 AM and 11:30 AM Resident #1 began to become more agitated while sitting at the smoking doors, yelling out at staff stating let me out of this f***ing place, I want to go back to council bluffs. This nurse and a Certified Nursing Assistant (CNA) came up to resident, said CNA attempted to push resident in his wheelchair but he grabbed the CNA's hand, ripping off her finger nail. Resident began to laugh, yelling out and continued to talk to himself. By this time resident had pushed himself to the nurses station and began yelling at another resident (Resident #2), the situation escalated, both residents began yelling and cursing at each other in-between dining area and nurse's station. Resident #1 then stood up out of his wheelchair and Resident #2 stood up out of his wheelchair as well. Resident #1 then stepped forward, striking Resident #2 in the face using a closed fist. This nurse and CNA were able to separate these residents prior to any further physical altercations occurring. Review of Resident #1's care plan with a revision date of 10/3/2025 revealed it lacked information about the resident to resident altercation that took place on 9/27/2025. 2) According to the quarterly MDS with a reference date of 9/8/2025, documented Resident #2 had a BIMS score of 6. A BIMS score of 6 suggested mild cognitive impairment. The MDS documented the following diagnoses for Resident #2: renal failure and metabolic encephalopathy. A Progress Note documented on 9/27/2025 at 3:01 PM: Resident #2 was hit in the face prior to noon meal by Resident #2 who was being aggressive. Resident #1 started yelling at Resident #2 which aggravated him, that led to both of these residents yelling at one another. It ended in Resident #1 hitting Resident #2 in the face. The situation was de-escalated by this nurse and CNA. This situation occurred at nurse's station. This resident was not injured, no new skin concerns observed related to altercation. Resident denied pain and discomfort. On 10/15/2025 at 11:18 AM the MDS Coordinator stated all departments are responsible for updating their portion of the resident care plans. When asked who would have been responsible for updating Resident #1 and Resident #2's care plans after the altercation on 9/27/2025, she stated the nurse in charge that day or whomever was doing the reportable incident report. The MDS Coordinator was not in the building the weekend this incident took place but thought the care plan had been updated. On 10/15/2025 at 11:54 AM the Administrator acknowledged Resident #1 and Resident #2's care plans should have been updated to reflect the altercation that took place on 9/27/2025. She added the MDS Coordinator completes the Care Plans. Their care plans should include interventions to keep the residents safe, any medications that were adjusted and interventions to prevent this from happening again. The facility provided a document titled Comprehensive Person-Centered Care Plan with a last reviewed date of 10/23/2019, indicated each resident will have a person-centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care.</p>		