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	11/05/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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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(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 - Few	Based on clinical record review, resident and staff interviews and facility policy review the facility failed to separate Resident #1 and Resident #3 to prevent a resident-to-resident altercation. The facility reported a census of 39 residents.Findings Include:1) According to the Quarterly Minimum Data Set (MDS) assessment tool with a reference date of 9/13/2025, Resident #1 had a Brief Interview of Mental Status (BIMS) score of 3. A BIMS score of 3 suggested severe cognitive impairment. The MDS listed the following diagnosis for Resident #1: hypertensive heart disease, anemia, renal failure, psychotic disorder (other than schizophrenia), mild cognitive impairment, insomnia, and metabolic encephalopathy.A Care Plan Focus Area with an initiation date of 1/15/2025 documented Resident #1 had a history or potential for delusions due to her cognitive status. The care plan documented she is redirectable, her short-term memory is impaired so diverting her attention can be effective. The care plan directed staff to reorient Resident #1 to her surroundings and situation.Record review revealed the following Progress Note documented by Staff A Registered Nurse (RN):a. on 10/18/2025 at 5:43 PM this nurse was called by dietary staff due to resident being verbally aggressive towards another resident. Upon approach of the table resident noted to be standing by table holding onto side of table very upset. Reported from other resident that Resident #1 hit Resident #3 in the middle of the chest because she thought it was her silverware. Residents separated from each other.2) According to the Quarterly MDS assessment tool with a reference date of 9/10/2025, Resident #3 had a BIMS score of 13. A BIMS score of 13 suggested no cognitive impairments. The MDS documented the following diagnoses for Resident #3: traumatic spinal cord dysfunction, paraplegia, anemia, hypertension, renal failure, neurogenic bladder, anxiety disorder, depression, bipolar, and insomnia.A Care Plan Focus Area with an initiation date of 7/10/2019 documented Resident #3 had a history of or the potential for physical and verbal behavioral symptoms related to anxiety and schizophrenia. Staff are encouraged to attempt to redirect Resident #3 from the behavior and educate hi on why the behavior is not appropriate. Record review revealed the following Progress Note documented by Staff A:a. on 10/18/2025 at 6:07 PM this nurse called for by dietary due to resident being verbally aggressive towards another resident. Upon approach of the table Resident #1 noted to be standing by table holding onto side of table very upset. His tablemate reported she hit him in the middle of the chest because she thought it was her silverware. Resident #3 stated well she came up to my table and thought my silverware was her's; she said that. He told her they were his and then she hit him right in the middle of the chest. Then you came over. Residents separated from other.On 11/4/2025 at 1:56 PM Resident #3 stated Resident #1 hit him on the chest and put his hands on the center of his chest. He denied any injuries and indicated this was the first time anything like this has happened. After she hit him, staff came to remove Resident #1 from his table and kept her away. He denies having further issues with Resident #1.On 11/5/2025 at 9:07 AM Staff A stated Resident #1 had hit a different resident the day prior and was on one-to-one supervision on 10/18/2025. As she was assisting another resident that had fallen, the Dietary Manager approached her and let her know Resident #1 was getting in Resident #3's face. Staff A asked her if she separated them and the Dietary Manager denied doing so. Staff A went over and Resident #1 was not happy but no doing anything. Staff A asked Resident #1 hey let's go this way and they both walked away from Resident #3's table. When she returned to speak with Resident #3 to see what happened, he stated she hit him on the chest and grabbed his shirt. He denied injuries.On 11/5/2025 at 9:48 AM the Dietary Manager stated she had given Resident #3 his coffee and silverware then made her way to the TV room. She came back and saw Resident #1 at Resident #3's table with a coffee lid in her hand. Resident #3 had his coffee cup in one hand and his silverware in his other hand. Resident #1 was also gripping his silverware. Resident #1 stated this is mine, cursed at Resident #3, she was being forceful. The Dietary Manager noticed Staff A was in the TV room and got her to assist with the situation. She later learned that Resident #1 hit Resident #3 after she dropped of his silverware and coffee. When asked if she separated the residents she denied doing so because she had a coffee pot in her hand and did not want to sit it down so Resident #1 could grab it. She stated she put the coffee pot in the kitchen then got Staff A. The Dietary Manager stated Resident #1 and Resident #3 were at Resident #3's dining room table that was next to the kitchen where she placed the coffee pot. She would have walked past that table to get Staff A. She added she could have attempted to separate them but Resident #1 can be aggressive.On 11/5/2025 at 10:00 AM Certified Nursing Assistant (CNA) stated if she came across the incident between Resident #1 and Resident #3 she would go and redirect Resident #1 away from the

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, facility investigative file review, resident and staff interviews, the facility failed to complete a thorough investigation after an altercation between Resident #1 and Resident #2 on 10/17/2025 and between Resident #1 and Resident #3 on 10/18/2025. The facility reported a census of 39 residents.Findings Include:1) According to the Quarterly Minimum Data Set (MDS) assessment tool with a reference date of 9/13/2025, Resident #1 had a Brief Interview of Mental Status (BIMS) score of 3. A BIMS score of 3 suggested severe cognitive impairment. The MDS listed the following diagnosis for Resident #1: hypertensive heart disease, anemia, renal failure, psychotic disorder (other than schizophrenia), mild cognitive impairment, insomnia, and metabolic encephalopathy.A Care Plan Focus Area with an initiation date of 1/15/2025 documented Resident #1 had a history or potential for delusions due to her cognitive status. The care plan documented she is redirectable, her short-term memory is impaired so diverting her attention can be effective. The care plan directed staff to reorient Resident #1 to her surroundings and situation.Record review revealed the following Progress Notes were documented:a. on 10/18/2025 at 4:26 AM last night we had an incident where Resident #1 was outside with the smokers and she grabbed Resident #2's wheelchair and started to push him. He asked her to stop, but she continued. He stated that he but his elbow back trying to get her hand off his wheelchair at which point she started slapping him several times in the shoulder with an open hand. A staff member separated them right away and escorted Resident #1 back inside and placed on a one-to-one while awake.b. on 10/18/2025 at 5:43 PM this nurse was called by dietary staff due to resident being verbally aggressive towards another resident. Upon approach of the table resident noted to be standing by table holding onto side of table very upset. Reported from other resident that Resident #1 hit Resident #3 in the middle of the chest because she thought it was her silverware. Residents separated from each other.2) According to the Annual MDS assessment tool with a reference date of 9/13/2025, Resident #2 had a BIMS score of 12. A BIMS score of 12 suggested no cognitive impairment. The MDS documented the following diagnoses for Resident #2: Wernicke's encephalopathy, chronic lung disease, and adjustment disorder with mixed anxiety and depressed mood.A Care Plan Focus Areas with an initiation date of 1/9/2025 documented he was verbally aggressive at times, had poor impulse control, and explosive behaviors at times in public places. Record review revealed the following Progress Note was documented:a. on 10/17/2025 at 7:45 PM had an incident where Resident #1 was outside with the smokers and she grabbed Resident #2's wheelchair and started to push him. He asked her to stop, but she continued. He stated that he but his elbow back trying to get her hand off his wheelchair at which point she started slapping him several times in the shoulder with an open hand. A staff member separated them right away. Resident #2 declined any injury and skin looked within normal limits.3) According to the Quarterly MDS assessment tool with a reference date of 9/10/2025, Resident #3 had a BIMS score of 13. A BIMS score of 13 suggested no cognitive impairments. The MDS documented the following diagnoses for Resident #3: traumatic spinal cord dysfunction, paraplegia, anemia, hypertension, renal failure, neurogenic bladder, anxiety disorder, depression, bipolar, and insomnia.A Care Plan Focus Area with an initiation date of 7/10/2019 documented Resident #3 had a history of or the potential for physical and verbal behavioral symptoms related to anxiety and schizophrenia. Staff are encouraged to attempt to redirect Resident #3 from the behavior and educate hi on why the behavior is not appropriate.Record review revealed the following Progress Noted documented by Staff A:a. On 10/18/2025 at 6:07 PM this nurse called for by dietary due to resident being verbally aggressive towards another resident. Upon approach of the table Resident #1 noted to be standing by table holding onto side of table very upset. His tablemate reported she hit him in the middle of the chest because she thought it was her silverware. Resident #3 stated well she came up to my table and thought my silverware was her's; she said that. He told her they were his and then she hit him right in the middle of the chest. Then you came over. Residents separated from each other.The facility was asked to provide their investigative file for the resident-to-resident altercation on 10/17/2025 involving Resident #1 and Resident #2. The facility provided the following information: a summary of their investigation, Resident #1's face sheet, medication changes prior to and after the altercation, psychological services progress notes, progress notes, care plan, and clinical treatment plan reviews (plan of care); Resident #2's facesheet and care plan. The investigative file lacked staff interviews/statements and resident statement/interviews.The facility was asked to provide their investigative file for the resident-to-resident altercation on 10/18/2025 involving Resident #1 and Resident #3. The facility provided the following

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, clinical record review, facility document review and staff interviews the facility failed to provide proper supervision for 1 of 3 residents reviewed (Resident #1). On 10/17/2025 Resident #1 had an altercation with Resident #2 and was placed on one-to-one supervision. On 10/18/2025 staff failed to provide one-to-one supervision which resulted in an altercation involving Resident #1 and Resident #3. The facility reported a census of 39 residents.According to the Quarterly Minimum Data Set (MDS) assessment tool with a reference date of 9/13/2025, Resident #1 had a Brief Interview of Mental Status (BIMS) score of 3. A BIMS score of 3 suggested severe cognitive impairment. The MDS listed the following diagnosis for Resident #1: hypertensive heart disease, anemia, renal failure, psychotic disorder (other than schizophrenia), mild cognitive impairment, insomnia, and metabolic encephalopathy.A Care Plan Focus Area with an initiation date of 1/15/2025 documented Resident #1 had a history or potential for delusions due to her cognitive status. The care plan documented she is redirectable, her short-term memory is impaired so diverting her attention can be effective. The care plan directed staff to reorient Resident #1 to her surroundings and situation. On 10/18/2025 her care plan was updated to include the following intervention: resident placed on one-to-one supervision, while awake, due to increased delusions.On 11/4/2025 during continuous observations Resident #1 wandered throughout the facility. Staff would redirect her when she would go to exit doors. Other residents were able to redirect her when Resident #1 would attempt to move wheelchairs or items that were not hers.Record review revealed the following Progress Notes were documented:a. on 10/18/2025 at 4:26 AM last night we had an incident where Resident #1 was outside with the smokers and she grabbed Resident #2's wheelchair and started to push him. He asked her to stop, but she continued. He stated that he but his elbow back trying to get her hand off his wheelchair at which point she started slapping him several times in the shoulder with an open hand. A staff member separated them right away, escorted Resident #1 back inside and placed on a one-to-one while awake.b. on 10/18/2025 at 5:43 PM this nurse was called by dietary staff due to resident being verbally aggressive towards another resident. Upon approach of the table resident noted to be standing by table holding onto side of table very upset. Reported from other resident that Resident #1 hit Resident #3 in the middle of the chest because she thought it was her silverware. Residents separated from each other.The facility provided a screenshot of a conversation on a patient-centered secured healthcare specific communication platform between staff and Resident #1's Primary Care Physician (PCP):a. on 10/18/2025 at 4:06 AM facility reported: last night we had an incident where Resident #1 was outside with the smokers and she grabbed Resident #2's wheelchair and started to push him. He asked her to stop, but she continued. He stated that he but his elbow back trying to get her hand off his wheelchair at which point she started slapping him several times in the shoulder with an open hand. A staff member separated them right away, escorted Resident #1 back inside and placed on a one-to-one while awake.b. on 10/18/2025 at 9:09 AM the PCP responded: follow facility protocol for resident-to-resident and update psych.c. on 10/18/2025 at 5:30 PM the PCP wrote the following message: on 10/18/2025 at 5:25 PM, the facility called, another resident-to-resident event. PCP reviewed orders over the last 2 weeks, staff noted psych is involved and adjusted her Ativan (antianxiety) recently. Management requested Emergency Department (ED) transfer for psych evaluation.On 11/4/2025 at 2:49 PM the MDS Coordinator stated at the time of the incident that took place on 10/18/2025, Resident #1 was on on-to-on supervision while awake. When asked if there was documentation for her one-to-one supervision that staff completed on 10/17/2025 and 10/18/2025 as the resident's record had documentation started on 10/19/2025. She was unable to find documentation they would fill out. She stated the one-to-one supervision started 10/17/2025 through 10/21/2025. She verified at the time of the incident on 10/18/2025, Resident #1 was on one-to-one supervision. The MDS Coordinator was asked to describe what one-to-one supervision meant; she stated staff are to be with Resident #1 at all time, even when she is up and walking. When in the dining room Certified Nursing Assistants (CNAs) and/or nurses can provide that one-to-one supervision. When asked how the incident happened if Resident #1 was on one-on-one supervision. When asked for policies, procedures, protocols or guidelines that staff are to follow when a resident is under one-to-one supervision, she stated she was locked out the drive that contains items like that. She has been locked out since October.On 11/5/2025 at 9:07 AM Staff A Registered Nurse (RN) stated after the first incident with Resident #1 hitting Resident #2, Resident #1 was on one-to-one supervision. On 10/18/2025 they had to move her between each staff member working that day. Around supper time, another resident fell in the TV