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	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Manor	737 North Highway St. 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, staff interviews, and facility policy review, the facility failed to maintain a clean, comfortable and homelike environment free of possible hazards. The facility reported a census of 32 residents. Findings include: On 1/05/2026 at 10:50 am to 11:00 AM observation of the facilities main dining room, activities area, hallways surrounding the nurses station revealed several mismatching paint patterns on the walls after drywall repairs. Door frames between 3 main residential hallways and most of the residential rooms displayed chipped paint revealing varies color patterns and sharp edges from the excessive dents, scuffs, and scratches. Many doors with kickplates attached to the lower half corners revealed corners were no longer adhering to the doors, revealing broken and sharp edges. Near the nurses desk, a hallway leading to the dining room revealed on the right side of the entrance a wall edge molding pulled away from the corner, hanging loosely and had a small black nail attached to it. During an interview with the Maintenance Director on 1/06/2026 at 3:00 pm he stated he has been in the position for over a year and had completed some drywall repairs and was aware of the mismatching paint patches throughout the facility. He stated that he was waiting for the new color schemes that were in the process of being decided by the new management company that took over a few months ago. He further stated that some of those drywall repairs were completed last summer and he had enough supplies/budget to match the paint to the current pattern but he didn't want to paint twice. When asked about the wall edge molding by the dining room, he stated it's been there for about a month and a resident picked at it and pulled it. He stated that over half of the facility's surfaces need some type of superficial repairs and that it didn't look dignifying to residents. On 1/7/26 at 10:50 am an interview with the Administrator revealed a new company acquired the facility a few months ago and they inherited the current conditions of the facility but he stated his expectations were things should be fixed in a reasonable amount of time. On 1/7/2026 at 4:37 pm in an interview Staff C, CNA, stated the facility's environment was in need of some paint and had spots on walls where colors didn't match. She stated other staff and residents made comments about it too. Several black round chairs in the dining room that staff set on while providing feeding assistance to residents showed extensive signs of wear with peeling leather and needed to be replaced. A review of the facility provided policy titled Safe and Homelike Environment undated, documented the following:In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility, both inside and outside, maximizes resident independence and does not pose a safety risk. Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas. A homelike environment is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment. A determination of homelike should include the resident's opinion of the living environment.Orderly is defined as an uncluttered physical environment that is neat and well-kept.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on electronic health record (EHR) review, resident interviews, observations, policy review, and staff interviews the facility failed to provide an opportunity for a comprehensive care plan to be reviewed and revised by an interdisciplinary team composed of a resident and/or resident representative to allow developing the care plan and making decisions about his or her care and follow existing care plan interventions to 5 of 12 residents reviewed (Resident #2, #6, #24, #31 and #38). The facility reported a census of 32 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) score of 13 indicating no cognitive impairment. On 1/5/26 at 2:05 PM Resident #2 stated the facility does not invite him to participate in care conferences and he would if he was asked. On 1/6/26 at 12:22 PM Staff E, Social Services Supervisor stated Resident #2's POA is on vacation and will schedule the care conference for January 21st. Staff E stated care conferences are supposed to be completed quarterly. Staff E stated she had a care conference book and Resident #2 might have got missed. Staff E acknowledged Resident #2's care conference was missed in November. Staff E acknowledged care conferences were expected to be completed quarterly and Resident #2's last care conference was completed 7/17/25. Staff E explained Resident #2 had a care conference prior to that on 4/4/25. On 1/6/26 at 12:37 PM the DON stated the facility's expectation was care conferences would be completed quarterly. The DON acknowledged Resident #2's care conference was last completed on 7/17/25. 2. The MDS dated [DATE] documented Resident #24 had a BIMS of 14 indicating no cognitive impairment. On 1/5/26 at 12:51 PM Resident #24 stated he had not been invited to any care conferences during his time at the facility. On 1/6/26 at 12:22 PM Staff E stated Resident #24's last care conference was completed 9/3/25. Staff E acknowledged Resident #24's care conference was missed in November. Staff E stated she can complete a make up care conference as she does not currently have him scheduled this month. Staff E stated she was not sure why the care conference was missed. Staff E stated she would complete an audit to ensure all residents were in compliance. 3. The MDS dated [DATE] documented Resident #38 had a BIMS of 6 indicating severe cognitive impairment. Observation on 1/6/26 at 2:10 PM revealed Staff D, Activities Director walking with residents outside to smoke. Staff D assisted all residents to apply smoking aprons. Staff D lit the residents cigarettes with a lighter. Resident #38 was not present at the time. Staff D spoke to another staff member and asked them to ask Resident #38 if he wanted to come outside to smoke. Resident #38 walked outside to smoke at 2:11 PM past the DON who was holding the door open for him. Resident #38 sat down outside with a smoking apron on and smoked. Resident #38 got up to walk back inside. Staff D noticed (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #38 was not walking with a walker. Staff D put her right elbow out for Resident #38 to take and assisted Resident #38 to the entrance to the facility. Resident #38 walked from the entrance to his room by himself without a 4 wheeled walker. Review of Resident #38's EHR titled, Care Plan documented an intervention for ambulation for use of a four-wheeled walker initiated 1/5/26. On 1/8/26 at 12:42 PM Resident #38 stated sometimes he forgets his walker and the staff remind him to use his walker. Resident #38 explained when he forgot his walker staff brought the walker to him. Resident #38 stated he was used to walking without a walker and forgets at times. Resident #38 stated he does not mind using the walker but forgets to use it because has not had the walker long. On 1/6/26 at 2:37 PM Staff D stated she does not get the opportunity to take the residents outside to smoke very often. Staff D stated it is required that all residents wear a smoking apron outside while smoking. Staff D acknowledged she had access to the residents' care plans. Staff D stated normally Resident #38 should be using a walker. Staff D stated she did not notice till Resident #38 stood up to go back inside. Staff D stated Resident #38 had used the walker for a couple weeks now. Staff D stated normally Resident #38 has the walker all the time. Staff D acknowledged that she walked with Resident #38 back up to the facility entrance. Staff D explained she should have asked Resident #38 to remain seated and brought the walker to him. Staff D acknowledged the care plan documented Resident #38 required a 4 wheeled walker when ambulating. On 1/6/26 at 3:07 PM the DON stated after she thought about the ambulation of Resident #38 she noticed he was not using a walker when he went outside to smoke. The DON stated her expectation was that the staff would have gone inside and brought the walker back out to Resident #38 to ambulate back to the room. The DON stated her expectation was staff would offer Resident #38 the use of a walker when he forgot. 4. Review of Resident #6's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. The MDS further revealed Resident #6 utilized a urostomy (a surgical diversion that creates an opening (stoma) in the abdomen to allow urine to exit the body into an external pouch). The MDS then revealed diagnoses of renal insufficiency, neurogenic bladder (a condition where nerve damage from issues in the brain, spinal cord, or peripheral nerves disrupts normal bladder control, causing problems like incontinence, retention, or incomplete emptying due to the bladder and sphincter muscles not working together properly), and paraplegia (paralysis affecting the lower half of the body). Interview on 1/5/26 at 2:07 PM with Resident #6 revealed he has had a catheter for a while now. Resident #6 then revealed that it is a urostomy that the catheter drainage bag is attached too. Review of Resident #6's Care Plan with a revision date of 12/17/25 revealed nursing staff are to observe/record/report to the Medical Doctor for signs and symptoms of a urinary tract infection including no output of urine. Review of Resident #6's EHR revealed no documentation of urinary outputs to review. 5. Review of Resident #31's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. The MDS further revealed that Resident #31 utilized a nephrostomy tube (a small tube inserted through the skin in the lower back directly into the kidney to drain urine when there's a (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blockage or injury, diverting it to an external bag to relieve pain, prevent infection, and protect kidney function) as well as a urostomy. The MDS then revealed diagnoses of non-traumatic spinal cord dysfunction, renal insufficiency, neurogenic bladder, and paraplegia. Interview on 1/5/26 at 1:38 PM with Resident #31 revealed that he had nephrostomy tubes, and that the tubes were just changed by the physician. Review of Resident #31's Care Plan with a revision date of 12/18/25 revealed nursing staff are to observe/record/report to the Medical Doctor for signs and symptoms of a urinary tract infection including no output of urine. Review of Resident #6's EHR revealed no documentation of urinary outputs to review. Interview on 1/7/26 at 2:55 PM with Staff A Licensed Practical Nurse (LPN) revealed that staff do not record urine outputs in the computer system, and she tries to make sure staff at least tell her what the urine outputs are. Staff further revealed that she would need to know if she needs to notify the physician for low outputs or changes in urination. Staff A then restated that staff do not chart this in the computer system. Interview 1/07/2026 at 3:17 PM with the Assistant Director of Nursing (ADON) revealed that catheters should be being monitored for output. Interview at 1/7/26 at 3:26 PM with the Director of Nursing (DON) revealed that catheters/urostomies should be monitored, and drainage should be reported to the nurses from the Certified Nursing Assistants (CNAS). The DON then revealed that her expectation would be for outputs to be recorded. Review of a facility provided policy titled, Comprehensive Care Plans with an implementation date of 11/3/25 revealed: a. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, Electronic Health Record (EHR) review, resident interviews and policy review the facility failed to provide quality nursing care by not completing assessments related to symptomatic positive influenza A diagnosis and symptomatic respiratory illness or having interventions in place related to the illness for 4 of 4 resident reviewed (Resident #8, #9, #28 and #38). The facility reported a census of 32 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #8 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS also documented diagnoses of quadriplegia, generalized muscle weakness and need for assistance with personal care. On 1/5/26 at 1:00 PM Resident #8 stated he had a cough for the last couple days but was getting over it and also some loose stools. Resident #8 stated the facility had not asked him to isolate in his room or wear a mask. Resident #8 stated the illness had been going around to all the residents at the facility. Review of Resident #8's (Medication Administration Records - Treatment Administration Records) MAR-TAR documented a physician's order that started 1/4/26 for guaifenesin oral liquid 100mg/5mL to give 10mL by mouth every 8 hours as needed for cough and an order that started 1/5/26 for Mucinex oral tablet extended release 12 hour 600mg to give 1 tablet by mouth every 12 hours as needed for congestion for 10 days. Review of Resident #8's EHR titled, Progress Notes documented no respiratory assessment and no lung sounds. Review of Resident #8's EHR titled, Assessments documented no respiratory assessment or infection screen evaluation. 2. The MDS dated [DATE] for Resident #28 documented a BIMS score of 13 indicating no cognitive impairment. On 1/5/26 at 3:57 PM Resident #28 stated she had started coughing on 1/1/26. Resident #28 stated the facility did not test her but just assumed she had the flu like everyone else. Resident #28 explained she remained in her room till this morning. Resident #28 stated the facility staff did not ask her to wear a mask but she wanted to because she was still coughing. Review of Resident #28's EHR titled, MAR-TAR documented a physician's order that started 1/5/26 for benzonatate oral capsule 100mg to give one capsule by mouth 3 times a day for cough for 10 days. On 1/5/26 at 4:09 PM an observation of Resident #28's room revealed no Transmission Based Precautions (TBP), Enhanced Barrier Precautions (EBP) signs or Personal Protective Equipment (PPE) present outside of room or inside of room. No PPE present or TBP sign present inside of the room. On 1/5/26 at 3:57 PM an observation of Resident #28 wearing a mask at the dining table with a cough present during the interview. On 1/6/26 at 12:20 PM an observation of Resident #28 during the lunch meal without a mask with (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cough present throughout the lunch meal. Review of Resident #28's EHR titled, Progress Notes documented no respiratory assessment and no lung sounds. Review of Resident #28's EHR titled, Assessments documented no respiratory assessment or infection screen evaluation. 3. The Minimum Data Set (MDS) dated [DATE] documented Resident #38 had a Brief Interview for Mental Status (BIMS) score of 6 indicating severe cognitive impairment. On 1/5/26 at 2:33 PM Resident #38 observed coughing in his bedroom during the interview. Resident #38 stated he had been sick recently but was getting better. Resident #38 stated staff to not wear masks or gowns in his room when working with him. Review of document dated 1/2/26 titled, Emergency Department Patient Summary documented Resident #38 had a respiratory panel flu-RSV-Covid collected with discharge instructions influenza is an infection that affects your respiratory tract. Influenza is contagious and spreads easily from person to person. Review of Resident #38's EHR titled, MAR-TAR documented a physician's order that started 1/2/26 for benzonatate oral capsule 100mg to give one capsule by mouth 3 times a day for influenza for 10 days. Review of Resident #38's EHR revealed Resident #38 resided in room [ROOM NUMBER]-A. On 1/5/26 at 4:09 PM an observation of Resident #38's room revealed no TBP signs present outside of room or inside of room. Observation continued to reveal EBP signs outside of the door with PPE available on the back of the door. Signage determined to be for roommate with supra-pubic catheter present. Review of Resident #28's EHR titled, Progress Notes documented no respiratory assessment and no lung sounds. Review of Resident #28's EHR titled, Assessments documented no respiratory assessment or infection screen evaluation. On 1/6/26 at 2:37 PM an observation of Resident #38 smoking revealed Resident #38 had frequent coughing episodes during that activity. Resident #38 sat at the end of the table around other residents who were smoking. Review of document with date printed 1/5/26 titled, CMS 802 Resident Matrix documented no residents in Transmission Based Precautions (TBP). On 1/5/26 at 11:40 AM the Director of Nursing (DON) stated she would double check but currently no resident at the facility was in TBP. On 1/6/26 at 11:30 AM Staff F, Registered Nurse (RN) stated 4 residents went to the hospital this last weekend. Staff F reported the 4 residents were sent out for the same concerns. Hypotension, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tachycardia hypoxia, general complaints of weakness. Staff F stated Resident #9 had influenza A, pneumonia, acute kidney injury and septic shock. Staff F said Resident #30 was sent to the hospital for acute hypoxic, respiratory failure, influenza A and bilateral bronchitis. Staff F stated Resident #1 was admitted for influenza A and bilateral bronchitis. Staff F explained the facility does not test for influenza basically but provided symptomatic care. Staff F stated Resident #38 was discovered to have a positive influenza A diagnosis because he was sent out for weakness and tested positive at the hospital. Staff F explained Resident #9 was the first resident that tested positive for influenza A at the facility. Staff F explained Resident #9 asked to be sent to the hospital on an overnight shift. Staff F explained she did not know why, maybe because he did not feel good. Staff F said the hospital did a 4 plex test and Resident #9 tested positive for influenza A. Staff F stated she had been encouraging masks to the staff when going into the residents rooms with any respiratory illness symptoms. Staff F stated Resident #28 was sick and the facility did not test her but obviously she had the flu. Staff F stated she was hoping and praying if the residents were symptomatic there would be assessments being completed. Staff F stated the on call physician was aware influenza was in the building. Staff F stated she would do a focused respiratory assessment every 6 hours to ensure they are not declining more with lung sounds and vitals. Staff F stated with this bout of the influenza the symptoms are mainly weakness and respiratory issues. Staff F stated when Resident #8 tested positive she put EBP signage and PPE outside of the door. Staff F stated she was never told to do so. Staff F stated staff were instructed to put the EBP and PPE away but did not remember who instructed them to do so. On 1/6/26 at 12:11 PM Staff G, RN stated standard precautions required with all resident care. Staff G stated if the resident was coughing he would request the resident to stay in their room. Staff G explained he did not know if there are any residents who currently have influenza. Staff G explained he did not think any residents were tested but were treated as a preventative measure. Staff G said he had cared for Resident #9 and #38 but he was not assessing the two. Staff G stated Resident #28 told him she was not coughing but was just wearing a mask in the hallway. Staff G explained there was no assessment required unless the resident had shortness of breath. Staff G stated he did not see any signs or symptoms of the residents that he cared for that would prompt him to assess lung sounds. On 1/8/26 at 1:03 PM Staff H, Certified Nurse Assistant (CNA) explained Resident #38 had returned from the hospital after a fall positive for influenza A. Staff H explained when Resident #38 returned from the hospital the staff were not required to wear masks or gowns when care was completed. Staff H stated she wore a mask because she had a cough herself. Staff H stated the staff were not required to wear gowns when they worked with Resident #38. Staff H explained staff were not required to wear gowns or a mask in Resident #8, #9, #28, or #38 rooms until after the survey team arrived at the facility. Staff H acknowledged all of these residents had respiratory symptoms prior to the weekend. On 1/7/26 at 1:11 PM the DON stated outbreak status was described as 2 or more confirmed cases of influenza. The DON acknowledged they did not follow the policy for outbreak status. The DON stated there was confusion because of the recent change in ownership and a policy change. The DON explained her expectation was a respiratory assessment with lung sounds and vitals would be completed every shift if the resident had a positive influenza test or any respiratory symptoms. The DON acknowledged the assessments were not completed appropriately for Residents #8, #9, #28, and #38. On 1/7/26 at 1:24 PM Staff I, Licensed Practical Nurse (LPN) / Infection Preventionist (IP) / (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assistant Director of Nursing (ADON) stated what should have happened after the one resident tested positive she would recommend isolation and test with PCR and would continue the isolation based on the policy. Staff I explained Resident #9 tested positive for influenza A on the 12/31/25, Resident #38 tested positive for influenza A in the hospital and returned to the facility, Resident #36 was put on Tamiflu through hospice because of symptoms but did not get tested, Resident #8 had symptoms but was not tested, then Resident #1 and #30 tested positive at the hospital, Resident #6 had symptoms 1/5/26 with negative chest x-ray, Resident #36 had symptoms on 1/6/26 but were waiting on the lab results and PCR currently. Staff I stated isolation precautions for droplets were in place now for Residents #8, #9, #28, #30, #34, #36 and #38. Staff I acknowledged droplet precautions with TBP signs were not in place on these residents before 1/7/26. Staff I stated if the facility followed the policy the residents all should have been tested for influenza. Staff I explained vitals and respiratory assessments should have been completed every shift. Staff I stated masking was not mandated to the staff but could encourage the masking. Staff I explained there were signs that would be put up for public knowledge. Staff I explained there should have been 7 days of charting. Staff I stated there should have been charting every shift with vitals and lung sounds. Staff I acknowledged assessments and interventions were not in place and completed appropriately. Staff I acknowledged the local or state public health department should have been notified as well. Staff I explained per the facility's policy 1 positive influenza diagnosis with any other respiratory illnesses among other residents would be considered outbreak status. On 1/7/26 at 1:42 PM Staff J, Medical Director explained any total number of residents greater than 10% would be considered outbreak status. Staff J stated the residents should have orders for Tamiflu or should have been offered. Staff J explained signage would be good outside of the building for public awareness. Staff J stated nursing staff should talk to the physician or the provider to determine if testing is needed. Staff J stated if there was an outbreak determined at the facility he would think everyone should be tested that was symptomatic. On 1/7/26 at 5:06 PM the DON stated she had concerns with differences in policies during the transition of ownership. The DON explained previously when residents displayed symptoms of respiratory symptoms the residents would not be required to wear a mask or stay in their room. The DON stated she was aware of the situation with the influenza A outbreak at the building. The DON acknowledged the outbreak was not handled the appropriate way. The DON explained when Staff I returned from vacation symptoms were tracked and signs were hung. The DON stated she would have expected assessment would have been completed on the residents that were symptomatic. The DON stated the facility's expectation was vitals and assessments every shift for 7 days. The DON explained the assessment would contain a full vitals and listen to the lungs and then a final assessment 24 hours status post. The DON stated the assessment would be found in progress notes. The DON explained the residents who were symptomatic or tested positive for influenza A should have had PPE available in their rooms with TBP signs posted for droplet precautions. 4. The MDS dated [DATE] for Resident #9 documented a BIMS score of 08 indicating moderate cognitive impairment. The MDS listed the following active diagnoses: non-Alzheimer's dementia, seizure disorder/epilepsy, and asthma/COPD. The Electronic Health Record (EHR) Progress notes documented Nurse Note for Resident #9 on 12/5/2025 at 5:51am resident was at the nurses station stating he is not feeling well he has a head cold. Nurse assessed the resident and took vitals and noted they were within normal limits but had audible wheezing and nasal congestion. Resident #9 asked for his inhaler and was given the treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility did not have documented nursing assessments or interventions between 12/5/25 and 12/12/25. On 12/12/2025 at 9:42 am General Progress Note documented a physician visit and new orders for Guaifenesin 600mg tablets by mouth for 14 days for congestion and upper respiratory infection. The facility did not have documented nursing assessments or interventions between 12/12/25 and 1/1/26. On 1/1/2026 at 1:13 am Progress notes documented a transfer to hospital summary note. Around 2000 the resident called and stated that he was coughing and he was not feeling well. He also requested to go to the hospital because he thought he was having pneumonia. He even called his Power of Attorney (POA) and the POA called the facility. On assessment, he mentioned he was coughing and was not feeling well. There was not signs of shortness of breath (SOB) and wheezing. He was alert and oriented. His blood pressure was very high 217/98, but the rest of the vitals was within the normal limits. About an hour later the Emergency Medical Services (EMS) arrived to transport Resident #9 to the ER. The hospital called the facility and informed them Resident #9 tested positive for Influenza A and will be returning shortly. Progress note on 1/1/2026 at 6:32 am documented Resident #9 returned from the hospital and isolation precautions were initiated, new medications were prescribed for the flu, Tamiflu Oral Capsule 75 MG for Influenza A for 5 Days, and Albuterol Nebulizer 4 times a day for 10 days. Progress note on 1/1/2026 at 5:42 pm documented Resident #9 complained of weakness and general pain all over, pain rate 5/10 on 0-10 pain scale. His Tamiflu medication has not arrived from the pharmacy and the facility staff documented it was unlikely to arrive that evening from the pharmacy. The facility did not have documented nursing assessments or interventions between 1/1/26 and 1/5/26. Progress note on 1/5/2026 at 10:56 am documented Resident #9 was doing well overall post flu diagnosis and his blood pressure was stable. The facility did not have documented nursing assessments or interventions between 1/5/26 and 1/8/26. Progress note on 1/8/2026 at 2:50 pm documented a nursing intervention implemented to complete respiratory assessment and vital signs every shift until the end that day for due to Influenza A, encourage isolation for 7 days and additional 24 hours, and to use droplet precautions (gown, gloves, mask and face shield).

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Oakland Manor	737 North Highway St. Oakland, IA 51560

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, staff interviews, and policy review the facility failed to provide range of motion (ROM) services to a resident with limited ROM to prevent further decrease in range of motion or development of contractures for 1 of 14 residents reviewed (Resident #8). The facility reported a census of 32.Findings include:The Minimum Data Set (MDS) dated [DATE] for Resident #8 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS also documented diagnoses of quadriplegia, generalized muscle weakness and need for assistance with personal care. On 1/5/26 at 1:00 PM Resident #8 stated he does not have a restorative program or see therapy but would like to participate in therapy. Review of Resident #8's EHR documented no restorative, occupational, or physical therapy plans.On 1/7/26 at 2:16 PM Staff I, Assistant Director of Nursing (ADO) stated there is no restorative program at the facility. On 1/7/26 at 2:19 PM Staff L, Director of Rehab stated the facility had a restorative program for a little bit. Staff L explained restorative programs were developed for some residents but then restorative was stopped. Staff L acknowledged the restorative program was around during 7/25. Staff L stated there were residents currently at the facility that would benefit from being on a restorative program. Staff L stated Resident #8 could benefit from a restorative program. Staff L stated Resident #19 could use some more cuing to come down to use the gym while at the facility. Staff L stated Resident #21 would benefit from a restorative program. Staff L explained Resident #20 could use a restorative program because he really wants to do more but he only gets 12 visits at a time when is on therapy. Staff L stated anyone who was currently at the facility that was on a restorative program earlier in the year could benefit from a restorative program currently. Staff L revealed previous restorative programs for Residents #6, #7, #8, #9, #19, #20, #21, #25 #27, #34, #36, #37, #38 and #40 who currently reside at the facility. Staff L stated all of those residents would benefit from a restorative program. Staff L explained she could not think of any resident that had decreased function without a restorative program. Staff L stated if there was decreased function it would be noticed on her quarterly evaluation and that resident would then be picked up by therapy.On 1/7/26 at 4:30 PM the DON stated she felt there were some residents that would benefit from a restorative program at the facility. The DON stated there was not a direct Registered Nurse (RN) to cover the restorative program with the previous owners of the facility. The DON stated she would like to implement a restorative program at the facility. The DON stated there was restorative in July but there was no training with the restorative aide that was providing the restorative to the residents. The DON explained within the last 8 weeks there had been so many changes there had not been the right time to discuss the restorative department. The DON stated there was not enough staff to assign a staff as the restorative aide at that current time. Review of Policy implemented 11/8/25 titled, Restorative Nursing Programs documented It was the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. Cognitive and physical functioning of all residents will be assessed in accordance with the facility's assessment protocols. The interdisciplinary team, with the support and guidance from the physician, will assure the ongoing review, evaluation, and decision making regarding the services needed to maintain or improve resident's abilities in accordance with the resident's comprehensive assessment, goals, and preferences. Nursing personnel are trained on basic, or maintenance nursing care that does not require the use of a qualified therapist or licensed nurse oversight. This training may include, but is not limited to maintaining proper positioning and body alignment, encouraging and assisting residents, as needed, in turning and position changes, encouraging residents to remain active and assisting with any exercises according to the plan of care, Promoting independence in ADLs, assisting residents with range of motion exercises, performing (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	passive range of motion for residents who lack active range of motion ability, promoting continence with various toileting and/or bowel and bladder training activities. All residents will receive maintenance nursing services as described above, as needed, by certified nursing assistants. The Restorative Nurse and restorative aides receive additional training on restorative nursing program activities upon hire and as needed. Residents, as identified during the comprehensive assessment process, will receive services from restorative aides when they are assessed to have a need for restorative nursing services. These services may include passive or active range of motion, splint or brace assistance, bed mobility training, training and skill practice in transfers or walking, training and skill practice in dressing and/or grooming. Residents may receive restorative nursing services upon admission when not a candidate for specialized rehabilitation services, when restorative needs arise during the course of a longer-term stay, in conjunction with specialized rehabilitation therapy, or upon discharge from therapy.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, observation, resident interviews, and staff interviews the facility failed to provide adequate response from nursing staff to assure residents safety by not responding to call lights in a timely manner for 2 of 12 residents reviewed (Resident #6 and #16). The facility reported a census of 32 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #16 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS also documented Resident #16 was always incontinent of urine and bowels. On 1/5/26 at 3:05 PM Resident #16 stated it frequently takes longer than 15 minutes to answer the call light. Resident #16 stated staff not answering call lights within 15 minutes happened frequently on both shifts equally. 2. During continuous observation on 1/5/26 at 12:46 PM until 1:02 PM (16 minutes) a call light was observed to be unanswered in the East hallway. Review of Resident #6's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. The MDS further revealed diagnoses of renal insufficiency, neurogenic bladder (a condition where nerve damage from issues in the brain, spinal cord, or peripheral nerves disrupts normal bladder control, causing problems like incontinence, retention, or incomplete emptying due to the bladder and sphincter muscles not working together properly), and paraplegia (paralysis affecting the lower half of the body). Interview on 1/5/26 at 2:04 PM with Resident #6 revealed he had been waiting to lay down, and had his call light on. Resident #6 further revealed that it had been around 20 minutes at this time, and he was watching his watch. Resident #6 then revealed that this happens from time to time. Interview 1/7/26 at 8:21 AM with the Director of Nursing (DON) revealed her expectation is for call lights to be answered within a timely manner of 15 minutes or less. 3. During a resident council meeting held 1/8/26 at 10:46 AM with residents #12, #13, #16, #28, and #37 revealed call lights can take longer than 15 minutes at most shift changes. Review of a facility provided policy titled, Call Lights: Accessibility and Timely Response with an implementation date of 11/9/25 revealed: a. All staff members who see or hear an activated call light are responsible for responding.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on facility document review, and staff interviews, the facility failed to employ a clinically qualified nutrition professional by not having a certified dietary manager (CDM). The facility reported a census of 32 residents.Findings include: Interview 1/05/2026 at 10:20 AM with the Dietary Manager revealed that she does not have a CDM. The Dietary Manager then revealed that since the company was bought out that she had to stop taking the classes in September of last year. The Dietary Manager then revealed that when they get more staff in the kitchen she would go back to more office work, and restart the classes. Interview 1/07/2026 at 8:42 AM with the Administrator revealed that he would expect the dietary manager to have a CDM certificate, and to finish the classes required. Follow up interview 1/07/2026 at 1:23 PM with the Administrator revealed he was unsure if there was a policy related to CDM, but his expectation would be for the dietary manager to have the appropriate education to be the CDM.Review of a facility provided document titled, Dietary Manager-Job Description with a copyright date of 2023 revealed:a. Required qualifications: 1. Minimum requirements include one of the following: a. Certification as a dietary manager. b. Certification as a food service manager. c. Has similar national certification for food service management and safety from a national certifying body.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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) review, policy review, resident interviews and staff interviews the facility failed to provide appropriate infection prevention practices when providing care to a resident with an indwelling catheter and a nephrostomy tube that was on Enhanced Barrier Precautions (EBP), failed to appropriately wear Personal Protective Equipment (PPE) during the sorting of laundry and failed to provide appropriated infection control standards for an outbreak of influenza A at the facility for 5 of 5 resident reviewed (Resident #8, #9, #28, #31 and #38). The facility reported a census of 32 residents.Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #8 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS also documented diagnoses of quadriplegia, generalized muscle weakness, presence of urogenital implant and need for assistance with personal care. On 1/5/26 at 1:00 PM Resident #8 stated he had a cough for the last couple days but was getting over it and also some loose stools. Resident #8 stated the facility had not asked him to isolate in his room or wear a mask. Resident #8 stated the illness had been going around to all the residents at the facility. Resident #8 stated staff do not always wear gowns when they emptied his supra-pubic catheter or when care was provided by staff. Review of Resident #8's Medication Administration Records - Treatment Administration Records (MAR-TAR), documented a physician's order that started 1/4/26 for guaifenesin oral liquid 100mg/5mL to give 10mL by mouth every 8 hours as needed for cough and an order that started 1/5/26 for Mucinex oral tablet extended release 12 hour 600mg to give 1 tablet by mouth every 12 hours as needed for congestion for 10 days. An order for a catheter size 24 Fr with 10cc normal saline instilled in the balloon to be changed once a month on the 19th. Review of Resident #8's EHR titled, Care Plan documented Enhanced Barrier Precautions in place initiated on 5/29/25 when bathing, dressing and transferring. Review of Resident #8's EHR titled, Progress Notes documented no respiratory assessment and no lung sounds. Review of Resident #8's EHR titled, Assessments documented no respiratory assessment or infection screen evaluation. On 1/6/26 at 3:45 PM observation of Staff H, Certified Nurse Assistant (CNA) and Staff K, CNA complete a full body lift transfer on Resident #8 for shower revealed Resident #8 was lying in his bed in only a brief, Resident #8 was covered with a blanket from the waist down, Staff K knocked on the door, Staff K read the Enhanced Barrier Precautions (EBP) sign on Resident #8's door, Staff K walked into the room, Staff K removed a gown from the back of the hanger on the back of the door, Staff K said I will need this gown for the shower, Staff K said I am going to take this gown to the shower room, Staff K left Resident #8's room, Staff [NAME] returned to Resident #8's room, Staff H completed hand hygiene, applied gloves, picked up catheter bag, hooked catheter bag to the full body lift, Staff K utilized the control to start lifting Resident #8, Resident #8 said his foot was stuck in the sling, Staff K stopped the lift, Staff H reached under the blanket and moved left leg / foot that was stuck under the right leg, Staff K resumed the lift process, Staff K pushed the lift over to the shower bed, Staff H guided Resident #8 with lift cloth to the appropriate space on the shower bed, Staff K lowered Resident #8 in the lift cloth to rest on the shower bed, Staff H removed left cloth from lift (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sling, Staff H leaned over Resident #8's abdomen, Staff H said she could not reach the upper lift cloth loop, Staff H stated I can not reach the hook, Staff H attempted several more times, Resident #8 lifted arm and picked lift cloth hook up at the wrist, Staff H was then able to unhook the lift cloth hook from the full body mechanical lift, Staff H removed gloves, completed hand hygiene, both Staff K and H assisted in transporting Resident #8 down the hall to the shower room. 2. The MDS dated [DATE] for Resident #28 documented a BIMS score of 13 indicating no cognitive impairment. On 1/5/26 at 3:57 PM Resident #28 stated she had started coughing on 1/1/26. Resident #28 stated the facility did not test her but just assumed she had the flu like everyone else. Resident #28 explained she remained in her room till this morning. Resident #28 stated the facility staff did not ask her to wear a mask but she wanted to because she was still coughing. Review of Resident #28's EHR titled, MAR-TAR documented a physician's order that started 1/5/26 for benzonatate oral capsule 100mg to give one capsule by mouth 3 times a day for cough for 10 days. On 1/5/26 at 4:09 PM an observation of Resident #28's room revealed no Transmission Based Precautions (TBP), Enhanced Barrier Precautions (EBP) signs or Personal Protective Equipment (PPE) present outside of room or inside of room. No PPE present or TBP sign present inside of the room. On 1/5/26 at 3:57 PM an observation of Resident #28 wearing a mask at the dining table with a cough present during the interview. On 1/6/26 at 12:20 PM an observation of Resident #28 during the lunch meal without a mask with cough present throughout the lunch meal. Review of Resident #28's EHR titled, Progress Notes documented no respiratory assessment and no lung sounds. Review of Resident #28's EHR titled, Assessments documented no respiratory assessment or infection screen evaluation. 3. The Minimum Data Set (MDS) dated [DATE] documented Resident #38 had a Brief Interview for Mental Status (BIMS) score of 6 indicating severe cognitive impairment. On 1/5/26 at 2:33 PM Resident #38 observed coughing in his bedroom during the interview. Resident #38 stated he had been sick recently but was getting better. Resident #38 stated staff to not wear masks or gowns in his room when working with him. Review of document dated 1/2/26 titled, Emergency Department Patient Summary documented Resident #38 had a respiratory panel flu-RSV-Covid collected with discharge instructions influenza is an infection that affects your respiratory tract. Influenza is contagious and spreads easily from person to person. Review of Resident #38's EHR titled, MAR-TAR documented a physician's order that started 1/2/26 for benzonatate oral capsule 100mg to give one capsule by mouth 3 times a day for influenza for 10 days. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/5/26 at 4:09 PM an observation of Resident #38's room revealed no TBP signs present outside of room or inside of room. Observation continued to reveal EBP signs outside of the door with PPE available on the back of the door. Signage determined to be for roommate with supra-pubic catheter present. Review of Resident #28's EHR titled, Progress Notes documented no respiratory assessment and no lung sounds. Review of Resident #28's EHR titled, Assessments documented no respiratory assessment or infection screen evaluation. On 1/6/26 at 2:37 PM an observation of Resident #38 smoking revealed Resident #38 had frequent coughing episodes during that activity. Resident #38 sat at the end of the table around other residents who were smoking. Review of document with date printed 1/5/26 titled, CMS 802 Resident Matrix documented no residents in Transmission Based Precautions (TBP). On 1/5/26 at 11:40 AM the Director of Nursing (DON) stated she would double check but currently no resident at the facility was in TBP. On 1/6/26 at 11:30 AM Staff F, Registered Nurse (RN) stated 4 residents went to the hospital this last weekend. Staff F reported the 4 residents were sent out for the same concerns. Hypotension, tachycardia hypoxia, general complaints of weakness. Staff F stated Resident #9 had influenza A, pneumonia, acute kidney injury and septic shock. Staff F said Resident #30 was sent to the hospital for acute hypoxic, respiratory failure, influenza A and bilateral bronchitis. Staff F stated Resident #1 was admitted for influenza A and bilateral bronchitis. Staff F explained the facility does not test for influenza basically but provided symptomatic care. Staff F stated Resident #38 was discovered to have a positive influenza A diagnosis because he was sent out for weakness and tested positive at the hospital. Staff F explained Resident #9 was the first resident that tested positive for influenza A at the facility. Staff F explained Resident #9 asked to be sent to the hospital on an overnight shift. Staff F explained she did not know why, maybe because he did not feel good. Staff F said the hospital did a 4 plex test and Resident #9 tested positive for influenza A. Staff F stated she had been encouraging masks to the staff when going into the residents rooms with any respiratory illness symptoms. Staff F stated Resident #28 was sick and the facility did not test her but obviously she had the flu. Staff F stated she was hoping and praying if the residents were symptomatic there would be assessments being completed. Staff F stated the on call physician was aware influenza was in the building. Staff F stated she would do a focused respiratory assessment every 6 hours to ensure they are not declining more with lung sounds and vitals. Staff F stated with this bout of the influenza the symptoms are mainly weakness and respiratory issues. Staff F stated when Resident #8 tested positive she put EBP signage and PPE outside of the door. Staff F stated she was never told to do so. Staff F stated staff were instructed to put the EBP and PPE away but did not remember who instructed them to do so. On 1/6/26 at 12:11 PM Staff G, RN stated standard precautions required with all resident care. Staff G stated if the resident was coughing he would request the resident to stay in their room. Staff G explained he did not know if there are any residents who currently have influenza. Staff G explained he did not think any residents were tested but were treated as a preventative measure. Staff G said he had cared for Resident #9 and #38 but he was not assessing the two. Staff G stated Resident #28 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	told him she was not coughing but was just wearing a mask in the hallway. Staff G explained there was no assessment required unless the resident had shortness of breath. Staff G stated he did not see any signs or symptoms of the residents that he cared for that would prompt him to assess lung sounds. On 1/8/26 at 1:03 PM Staff H, Certified Nurse Assistant (CNA) explained Resident #38 had returned from the hospital after a fall positive for influenza A. Staff H explained when Resident #38 returned from the hospital the staff were not required to wear masks or gowns when care was completed. Staff H stated she wore a mask because she had a cough herself. Staff H stated the staff were not required to wear gowns when they worked with Resident #38. Staff H explained staff were not required to wear gowns or a mask in Resident #8, #9, #28, or #38 rooms until after the survey team arrived at the facility. Staff H acknowledged all of these residents had respiratory symptoms prior to the weekend. On 1/7/26 at 1:11 PM the DON stated outbreak status was described as 2 or more confirmed cases of influenza. DON acknowledged they did not follow the policy for outbreak status. The DON stated there was confusion because of the recent change in ownership and a policy change. The DON explained her expectation was a respiratory assessment with lung sounds and vitals would be completed every shift if the resident had a positive influenza test or any respiratory symptoms. The DON acknowledged the assessments were not completed appropriately for Residents #8, #9, #28, and #38. On 1/7/26 at 4:58 PM the DON stated the facility's expectation was the EBP policy would have been followed when providing care to Resident #8. The DON stated the facility's expectation was appropriate PPE would be donned prior to transfer of Resident #8. On 1/7/26 at 1:24 PM Staff I, Licensed Practical Nurse (LPN) / Infection Preventionist (IP) / Assistant Director of Nursing (ADON) stated what should have happened after the one resident tested positive she would recommend isolation and test with PCR and would continue the isolation based on the policy. Staff I explained Resident #9 tested positive for influenza A on the 12/31/25, Resident #38 tested positive for influenza A in the hospital and returned to the facility, Resident #36 was put on Tamiflu through hospice because of symptoms but did not get tested, Resident #8 had symptoms but was not tested, then Resident #1 and #30 tested positive at the hospital, Resident #6 had symptoms 1/5/26 with negative chest x-ray, Resident #36 had symptoms on 1/6/26 but were waiting on the lab results and PCR currently. Staff I stated isolation precautions for droplets were in place now for Residents #8, #9, #28, #30, #34, #36 and #38. Staff I acknowledged droplet precautions with TBP signs were not in place on these residents before 1/7/26. Staff I stated if the facility followed the policy the residents all should have been tested for influenza. Staff I explained vitals and respiratory assessments should have been completed every shift. Staff I stated masking was not mandated to the staff but could encourage the masking. Staff I explained there were signs that would be put up for public knowledge. Staff I explained there should have been 7 days of charting. Staff I stated there should have been charting every shift with vitals and lung sounds. Staff I acknowledged assessments and interventions were not in place and completed appropriately. Staff I acknowledged the local or state public health department should have been notified as well. Staff I explained per the facility's policy 1 positive influenza diagnosis with any other respiratory illnesses among other residents would be considered outbreak status. On 1/7/26 at 1:42 PM Staff J, Medical Director explained any total number of residents greater than 10% would be considered outbreak status. Staff J stated the residents should have orders for Tamiflu or should have been offered. Staff J explained signage would be good outside of the building for (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	public awareness. Staff J stated nursing staff should talk to the physician or the provider to determine if testing is needed. Staff J stated if there was an outbreak determined at the facility he would think everyone should be tested that was symptomatic. On 1/7/26 at 5:06 PM the DON stated she had concerns with differences in policies during the transition of ownership. The DON explained previously when residents displayed symptoms of respiratory symptoms the residents would not be required to wear a mask or stay in their room. The DON stated she was aware of the situation with the influenza A outbreak at the building. The DON acknowledged the outbreak was not handled the appropriate way. The DON explained when Staff I returned from vacation symptoms were tracked and signs were hung. The DON stated she would have expected assessment would have been completed on the residents that were symptomatic. The DON stated the facility's expectation was vitals and assessments every shift for 7 days. The DON explained the assessment would contain a full vitals and listen to the lungs and then a final assessment 24 hours status post. The DON stated the assessment would be found in progress notes. The DON explained the residents who were symptomatic or tested positive for influenza A should have had PPE available in their rooms with TBP signs posted for droplet precautions. 4. The Electronic Health Record (EHR) Progress notes documented a Nurse Note for Resident #9 on 12/5/2025 at 5:51am resident reported to staff symptoms of a head cold. Staff noted on assessment audible wheezing and nasal congestion. Staff did not initiate testing for flu-like symptoms and did not put isolation precautions in place. On 12/12/2025 at 9:42 am General Progress Note documented a physician visit and new orders for Guaifenesin 600mg tablets by mouth for 14 days for congestion and upper respiratory infection. Staff did not initiate testing to determine if Resident #9 had a flu and did not put isolation precautions in place after a diagnosis of Upper Respiratory Illness. On 1/1/2026 at 1:13 am Progress notes documented Resident #9 went to the ER and will be returning shortly after with a diagnosis of Influenza A. Progress note on 1/1/2026 at 6:32 am documented Resident #9 returned from the hospital and isolation precautions were initiated, new medications were prescribed for the flu, Tamiflu Oral Capsule 75 MG for Influenza A for 5 Days, and Albuterol Nebulizer 4 times a day for 10 days. Observation of Resident #9's room on 1/5/26 at 12:00 pm revealed no isolation precaution sign posted around the door prior to entering the room. No isolation cart located outside the room for staff to protect themselves prior to entering the room. Progress note on 1/8/2026 at 2:50 pm documented a nursing intervention implemented to complete respiratory assessment and vital signs every shift until the end that day for due to Influenza A, encourage isolation for 7 days and additional 24 hours, and to use droplet precautions (gown, gloves, mask and face shield). 5. Review of Resident #31's MDS 12/11/25 revealed a BIMS score of 15 indicating intact cognition. The MDS further revealed that Resident #31 utilized a nephrostomy tube (a small tube inserted through the skin in the lower back directly into the kidney to drain urine when there's a blockage or injury, diverting it to an external bag to relieve pain, prevent infection, and protect kidney function) as well as a urostomy. The MDS then revealed diagnoses of non-traumatic spinal cord dysfunction, renal insufficiency, neurogenic bladder, and paraplegia. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview 1/05/2026 at 1:38 PM with Resident #31 revealed that he has nephrostomy tubes and that the tubes were just changed by the physician. Tubing was observed to have dark brown/red urine in the tubing. It was further observed at this time that Resident #31's urine drainage bag noted to be hanging in the trash can at this time. Observation 1/06/2026 at 3:05 PM noted Resident #31's urine drainage bag hanging on the trash can at this time. Observation 1/07/2026 at 2:52 PM noted Resident #31's urine drainage bag hanging on the side of the trash can at this time. Interview 1/07/2026 at 3:26 PM with the DON revealed that catheter/urostomy drainage bags should not be hanging on trashcans as this is a concern with infection control. 6. Interview 1/06/2026 at 7:57 AM with Staff B Housekeeping/Laundry revealed that she only wears gloves, and not gowns when separating the clothes. No gowns were observed in the laundry room, and clothes in bins had been separated at this time. Interview 1/07/2026 at 1:53 PM with the ADON/IP revealed that she would like to see laundry staff wearing gowns when separating laundry. Interview 1/07/2026 at 2:09 PM with the DON revealed that she would expect laundry staff to wear gowns when separating laundry as this would be standard precautions. Review of a facility provided policy titled, Handling Soiled Linen with and implementation date of 11.9.25 revealed: a. All linen should be handled using standard precautions and treated as potentially contaminated.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, Electronic Health Record (EHR) review, policy review, resident interviews and staff interviews the facility failed to provide dignity and respect to 2 of 14 residents reviewed (Resident #8 and #12). The facility reported a census of 32 residents.Finding include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #8 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS also documented diagnoses of quadriplegia, generalized muscle weakness and need for assistance with personal care. An observation on 1/5/26 at 1:19 PM Staff C, Certified Nurse Assistant leave room [ROOM NUMBER]. Staff C walked down the hall to join another CNA in room [ROOM NUMBER]. An observation of Resident #8 in bed with no sheets or clothes only a brief on. Staff D, Activities Director knocked on the door on 1/5/26 at 1:28 PM and entered the room. Staff D delivered mail to Resident #8. On 1/5/26 at 1:29 PM Staff C walked down the hall from room [ROOM NUMBER] to room [ROOM NUMBER]. Staff C spoke with the resident in room [ROOM NUMBER], went down the hall, returned up the hall with lift cloth and returned to room [ROOM NUMBER]. On 1/5/26 at 1:32 PM Resident #8 turned the call light on. Another CNA requested help in room [ROOM NUMBER] from Staff C. On 1/5/26 at 1:36 PM Staff C told the CNA from room [ROOM NUMBER] she would be right back to see what Resident #8 needed. Staff C took dirty linen down the hall. On 1/5/26 at 1:37 PM CNA entered Resident #8's room to answer the call light. On 1/5/26 at 1:37 PM Staff C answered the call light in room [ROOM NUMBER]. On 1/5/26 at 1:39 PM an observation of Resident #8 with a blanket on. On 1/5/26 at 1:19 PM Resident #8 stated staff left to go get him some linen. Resident #8 stated he felt uncomfortable without a sheet on. Resident #8 stated he did feel there was a lack of dignity provided when laying in bed without a sheet on. On 1/5/26 at 1:32 PM Resident #8 stated it usually did not take that long for staff to return to cover him and that was why he turned the call light on. On 1/5/26 at 1:39 PM Resident #8 stated Staff C had covered him up and that was what he wanted. On 1/7/26 at 3:57 PM Staff C, CNA acknowledged that she was working morning shift on 1/5/26 giving showers. Staff C stated she did forget to put sheets on Resident #8's bed that morning. Staff C stated she was told she was not supposed to have a bottom sheet on the air mattress. Staff C stated when she returned to answer Resident #8's call light he asked to have the blanket put over him. Staff C stated she explained to Resident #8 that she was sorry and she got sidetracked. On 1/7/26 at 4:46 PM the Director of Nursing (DON) stated she would expect Resident #8 would have been covered before the staff left the room with the blanket. The DON said Staff C should provide the most dignity that she could for Resident #8. Review of policy with implemented date of 11/9/25 titled, Promoting/Maintaining Resident Dignity documented it was the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintained or enhanced the resident's quality of life by recognizing each resident's individuality. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. The resident's former lifestyle and personal choices will be considered (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when providing care and services to meet the resident's needs and preferences. All staff will maintain the resident's privacy. 2. Review of Resident #12's MDS dated [DATE] documented an admission to the facility on 6/30/25 and a Brief Interview for Mental Status (BIMS) score of 08 indicating moderate cognitive impairment. The MDS documented the following diagnoses: hemiplegia, diabetes, and depression. The MDS revealed Resident #12 depended on staff for total assistance with personal hygiene, upper and lower body dressing, and bathing. During an interview with Resident #12 on 1/7/26 at 4:15 pm she stated Staff P, CNA recently slapped her upper leg while putting her feet up in bed. She stated she was attempting to get out of bed and Staff P noticed her while walking by her room, she then entered her room, was very mean verbally and yelled at her, lifted her feet up and put them back in bed and at that time she tapped her upper leg. Resident #12 stated she told Staff P to get out of her room. During an interview with Staff P, CNA on 1/7/26 at 4:50 pm who worked at the facility for over 8 years, she revealed she assisted Resident #12 back into bed on 12/5/25 when she noticed that she was attempting to get out of bed. She was afraid that Resident #12 would fall since she couldn't walk on her own and all she could think about was safety. Resident #12 told her to leave the room and became visibly upset and said she hit her leg. Staff P stated she did not touch resident's upper leg during this action but Staff P went and reported it to the charge nurse immediately that she needed help with Resident #12. Shortly after the report, she was notified by the DON to leave the facility while they investigate the situation. During an interview with the DON on 1/8/26 at 12:21 pm she stated her expectation was for Staff P to ask for consent prior to touching a resident, verbalize actions during any cares such as pushing them in a wheelchair, pericare, show dignity, make them feel safe and respected. A review of the facility provided policy titled Abuse Prevention revised on 10/21/22 documented: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 other agencies providing services to our residents, family members. Legal guardians, surrogates, sponsors, friends, visitors, or any other individual. Mistreatment: inappropriate treatment or exploitation of a resident. Protection: Any allegation of abuses, or neglect, misappropriation or exploitation against any employee must result in his/her immediate suspension to protect the resident.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and facility policy review, the facility failed to identify non-pharmacological interventions and targeted behaviors related to high risk medications in 3 out of 5 sampled residents reviewed (Resident #5, #12, #20). The facility reported a census of 32 residents.Findings include:1. Review of Resident #5's Minimum Data Set (MDS) date 12/9/25 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS showed Resident #5 also took antidepressant medication during the review period. The MDS further revealed diagnoses of depression, diabetes, and respiratory failure.Review of Resident #5's Electronic Healthcare Record (EHR) page titled Medication Administration Record (MAR) revealed an order dated 9/19/26 for Citalopram 30 mg daily for major depressive disorder.Review of the Care Plan for Resident #5 with a revised date of 12/15/25 lacked non-pharmacological interventions and targeted behaviors with anti-depressant medications. 2. Review of Resident #12's MDS dated [DATE] revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The MDS documented Resident #12 also took antidepressant medication during the review period. The MDS further revealed diagnoses of depression, diabetes, and hemiplegia.Review of Resident #12's Electronic Healthcare Record (EHR) page titled Medication Administration Record (MAR) revealed an order dated 12/14/25 for Paroxetine 40 mg daily for major depressive disorder, Review of the Care Plan for Resident #12 with a revised date of 12/15/25 lacked non-pharmacological interventions and targeted behaviors with anti-depressant medications. 3. Review of Resident #20's MDS date 1/18/25 revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The MDS documented Resident #20 received antidepressant medication during the review period. The MDS further revealed diagnoses of non-Alzheimer's dementia, depression, anxiety, and bipolar disorder.Review of Resident #20's Electronic Healthcare Record (EHR) page titled Medication Administration Record (MAR) revealed an order dated 9/19/25 for Depakote 125 mg daily for bipolar disorder, an order dated 11/8/25 for Venlafaxine 75mg daily for bipolar disorder, an order dated 9/19/25 for Donepezil 5mg daily for dementia with other behavioral disturbance. Review of the Care Plan for Resident #20 with a revised date of 12/15/25 lacked non-pharmacological interventions and targeted behaviors with anti-depressant medications. Interview on 1/08/26 at 12:52 pm with the Director of Nursing (DON) stated she expected non-pharmacological interventions to be placed in the Care Plan for residents with psychotropic medications. The DON further acknowledged there were no non-pharmacological interventions currently on Residents #5, #12, and #20 Care Plans. Review of a facility provided policy titled Medication Therapy revised April 2007 documented: Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks.Medication use shall be consistent with an individual's condition, prognosis, values, wishes, and responses to such treatments.All medication orders will be supported by appropriate care processes and practices.All decisions related to medications shall include appropriate elements of the care process, such as:a. Adequately detailed assessment;b. Review of causes of symptoms;c. Consideration of the clinical relevance of symptoms and abnormal diagnostic test results;d. Principles of prescribing for the elderly; ande. Each resident's wishes, values, goals, condition, and prognosis.Upon or shortly after admission, and periodically thereafter, the staff and practitioner (assisted by the Consultant Pharmacist) will review an individual's current medication regimen, to identify whether:a. There is a clear indication for treating that individual with the medication;b. The dosage is appropriate;c. The frequency of administration and duration of use are appropriate; andd. Potential or suspected side effects are present.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, staff interviews, documentation reviews and facility policy review, the facility failed to thoroughly investigate and report immediately alleged violations related to mistreatment of 1 resident (Resident #12) out of 8 reviewed. The facility reported a census of 32 residents.Findings include:Review of Resident #12's MDS dated [DATE] documented an admission to the facility on 6/30/25 and a Brief Interview for Mental Status (BIMS) of 08 indicating moderate cognitive impairment The MDS documented the following diagnoses: hemiplegia, diabetes, and depression. The MDS revealed Resident #12 depended on staff for total assistance with personal hygiene, upper and lower body dressing, and bathing. During an interview with Resident #12 on 1/7/2026 at 4:15 pm she stated Staff P, CNA recently slapped her upper leg while putting her feet up in bed. She stated she was attempting to get out of bed and Staff P noticed her while walking by her room, she then entered her room, was very mean verbally and yelled at her, lifted her feet up and put them back in bed and at that time she tapped her upper leg. Resident #12 stated she told Staff P to get out of her room. During an interview with Staff P, CNA on 1/7/26 at 4:50 pm who worked at the facility for over 8 years, she revealed she assisted Resident #12 back into bed on 12/5/25 when she noticed that she was attempting to get out of bed. She was afraid that Resident #12 will fall since she couldn't walk on her own and all she could think about was safety. Resident #12 told her to leave the room and became visibly upset and said she hit her leg. Staff P stated she did not touch resident's upper leg during this action but Staff P went and reported it to the charge nurse immediately that she needed help with Resident #12. Shortly after the report, she was notified by the DON to leave the facility while they investigate the situation. A few days later she was notified by the facility that she was terminated. A personnel file review for Staff P revealed a document titled Corrective Action dated 12/8/25 documented On 12/5/25 Resident accused CNA of abuse, stating she threw my legs in bed and hit me. This DON did investigation-resulting in termination. Notice provided verbally by phone and signed by the the DON, Assistant DON and the Administrator on 12/8/25. In an interview with the DON on 1/07/2026 at 9:37 am who was in her position about 3 months revealed she did not make a report to the law enforcement about the abuse allegation by Resident #12 and Staff P hitting her leg. She stated she wasn't aware that a police report needed to be submitted at the time of the incident. She further revealed she did not interview any other residents if they felt abused. A review of the facility provided policy titled Abuse Prevention revised on 10/21/22 documented: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 other agencies providing services to our residents, family members. Legal guardians, surrogates, sponsors, friends, visitors, or any other individual. Procedure: steps to prevent, detect and report documented:Suspected or substantiated cases of resident abuse, neglect, misappropriation of property, or mistreatment shall be thoroughly investigated, documented, and reported to the physician, families, and/or representative, and as required by state guidelines. In addition, the facility will follow Section 1150B of the Social Security Act's time limits for reporting a reasonable suspicion of crime (immediately but no later than 2 hours if abuse or serious bodily injury and 24 hours for all others). In addition to reporting to the State Agency, a reasonable suspicion of crime or allegation of abuse, neglect, or misappropriation of resident property is to be reported to at least one law enforcement agency. It is the responsibility of all staff to provide a safe environment for the residents. Resident care and treatments shall be monitored by all staff, on an ongoing basis, so that residents are free from abuse, neglect, or mistreatment.Care will be monitored so that the resident's care plan is followed.The facility will not retaliate against any individual who lawfully reports a reasonable suspicion of crime.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, staff interviews, and policy review the facility failed to obtain bed hold notifications for 1 of 3 residents (Resident #40) reviewed. The facility reported a census of 32 residents.Findings Include: Review of Resident #40's Minimum Data Set (MDS) dated [DATE] revealed diagnoses of anxiety disorder, bipolar disorder, adult failure to thrive, and chronic kidney disease. Review of Resident #40's EHR page titled, Progress Notes revealed an entry dated 12/31/25 documenting that Resident #40 was transferred to the emergency room for evaluation. Further review of the progress notes revealed an entry dated 1/5/26 that Resident #40 was re-admitted back to the facility from a hospital stay. Review of the EHR page titled, Clinical Census revealed that Resident #40 had been in the hospital from [DATE] until 1/5/26. Interview on 1/8/26 at 9:22 AM with the Director of Nursing (DON) confirmed that Resident #40 was sent to the hospital on [DATE]. The DON then confirmed that no bed hold was obtained on this day for the resident being sent to the hospital. The DON further revealed that she would expect a bed hold to be completed.Review of a facility provided policy titled, Bed Hold Notice with a date implemented of 11/9/25 revealed:a. In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident within 24 hours.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review, staff interviews, and policy review, the facility failed to refer a resident with a negative Level I result for the Pre admission Screening and Resident Review (PASRR), who had an identified mental disorder, intellectual disability, or other related condition that was not addressed on PASRR completed prior to admission to the facility, to the appropriate state-designated authority for Level II PASRR evaluation and determination for 1 resident (Resident #24) reviewed for PASRR requirements. The facility reported a census of 32 residents.Finding include:The Minimum Data Set (MDS) dated [DATE] documented Resident #24 had a Brief Interview for Mental Status (BIMS) of 14 indicating no cognitive impairment. The MDS revealed Resident #24 had a diagnosis of Post Traumatic Stress Disorder (PTSD) dated 2/7/25. The MDS documented Resident #24's admission date of 2/7/25.Review of document dated 1/30/25 titled, Preadmission Screening and Resident Review documented no diagnosis of PTSD under the diagnosis of mental health diagnoses portion of the screening. Review of document dated 8/8/25 titled, Notice of PASRR Level 2 Outcome documented no diagnosis of PTSD under the diagnosis of mental health diagnoses portion of the screening. On 1/6/26 at 3:17 PM Staff E, Social Services Supervisor stated she does not usually have to update the level 1 PASSR. Staff E stated there was an updated PASSR completed on 9/5/24. Staff [NAME] stated Resident #24 had a PASRR updated on 8/8/25. Staff E acknowledged Resident #24's PASRR was non-compliant. Staff E explained Resident #24's PASRR did not have the diagnosis of PTSD and it should have been documented on both PASRR documents for 1/30/25 and 8/8/25. On 1/6/26 at 4:29 PM the Director of Nursing (DON) stated her expectation was the PTSD diagnosis for Resident #24 would have been documented on the PASSR and resubmitted.Review of policy implemented 11/9/25 titled, Resident Assessment Coordination with PASARR Program documented the facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Negative Level I Screen - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. A comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs. Any level II resident who experiences a significant change in status will be referred promptly to the state mental health or intellectual disability authority for additional resident review.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff interviews, and policy review the facility failed to provide respiratory care and services in accordance with professional standards of practice for 2 of 2 residents reviewed (Residents #27, #42) requiring the use of oxygen. The facility reported a census of 32 residents. Findings include: 1. Review of Resident #27's Minimum Data Set (MDS) dated [DATE] documented diagnoses of non-Alzheimer's dementia, Parkinson's disease, and depression. The Progress Notes in the Electronic Health Record (EHR) documented Resident #27 started receiving hospice services and was prescribed oxygen therapy via nasal cannula for comfort. An observation on 1/5/25 at 2:25 pm revealed oxygen was delivered via nasal cannula and the tubing attached to the oxygen concentrator located near the bed. The concentrator was turned on and set to deliver 2L/min of oxygen. The tubing did not have a label with the start date and staff initials. The tubing appeared flattened due to being jammed and stuck under the locked wheel of the bed on the left side of the headboard. Resident #9 had visible perspiration on his face and was breathing heavily. In an interview on 1/5/25 at 2:35 pm with Staff M, Certified Nursing Assistant (CNA) and Staff N, Hospice CNA after they provided hands-on cares to Resident #27, they did not notice the oxygen tubing was stuck under the wheel of the bed. After they provided the cares, the oxygen tubing was no longer stuck under the wheel of the bed. They checked vital signs on Resident #27 and his oxygen saturation level was at 90%. The oxygen concentrator after the CNAs provided cares was set at 4.5 L/min, both CNAs stated they didn't change the settings on the concentrator but they will notify the nurse about the settings. The CNAs also confirmed the nasal cannula oxygen tubing was not labeled. In an interview on 1/5/25 at 2:35 pm Staff C, CNA stated she checked on Resident #27 about every hour during her shift.On 1/5/26 at 2:58 PM Staff N, Hospice CNA returned back to Resident #27's room with a new tubing and a piece of tape, she stated the facility gave her new supplies and she will be labeling the new oxygen tube at this time. In an interview on 1/5/25 at 3:35 pm with Staff A, Licensed Practical Nurse (LPN), she revealed she did not complete an assessment on Resident #27 during her shift as there was no need for it because a Hospice nurse made a visit to assess the resident that morning. She also revealed she was not aware that Resident # 27's oxygen concentrator was set to 4.5L/min and CNAs didn't report it to her after they were aware it was set to 4.5L/min after they provided bedside cares.2. Review of Resident #42's MDS dated [DATE] documented an admission to the facility on [DATE]. The Electronic Health Record (EHR) review revealed a document titled Hospice orders on admission from Hospice services and on the orders it listed Oxygen therapy 1-4L via nasal cannula as needed for difficulty with breathing. An observation of Resident #42 on 1/5/26 at 1:30 pm revealed oxygen therapy was in place via nasal cannula and the concentrator set to 1.5L/min, the excess tubing was on the floor and kinked and no label with date/initials noted. Resident #42 appeared to be resting with eyes closed, not responding to a verbal greeting. A review of the EHR Medication Administration Record (MAR) and Baseline Care Plan for Resident #42 did not document a prescribed oxygen therapy. In an interview on 1/6/25 at 2:10 pm with Staff O, Registered Nurse (RN) hospice services, she reported Resident #42 was admitted to the facility with the oxygen order and the concentrator was delivered to the facility at the time of admission through their services. She confirmed the hospice company provided orders for oxygen as part of the admission documents since the resident was receiving hospice services through their company prior to admission to the facility. In an interview with the Director of Nursing (DON) on 1/6/25 at 2:40 pm stated her expectation was for the admitting staff to document oxygen therapy on the MAR and the baseline care plan at the time of the admission for new residents. The baseline care plan was to be completed within 24-48 hours of admission and she would follow up on the documentation. She also reported she didn't realize the oxygen therapy for Resident #42 was missed on the MAR and the baseline care plan and she will correct it. She stated the company policy for the oxygen tubing to be labeled and dated and replaced (continued on next page)

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	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Manor	737 North Highway St. 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weekly.A company provided policy titled Oxygen Administration dated November 9, 2025 documented: oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.Policy Explanation and Compliance Guidelines:Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control.Personnel authorized to initiate oxygen therapy include physicians, RNs, LPNs, and respiratory therapists.Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy.The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to:The type of oxygen delivery system.When to administer, such as continuous or intermittent and/or when to discontinue.Equipment setting for the prescribed flow rates.Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered.Monitoring for complications associated with the use of oxygen.Oxygen warning signs must be placed on the door of the resident's room where oxygen is in use.Cleaning and care of equipment shall be in accordance with facility policies for such equipment.