STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165254	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakview Nursing Home	511 East Center Conrad, IA 50621

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, facility investigation, and policy review, the facility failed to follow the transfer technique to safely transfer a resident for 1 of 3 residents reviewed (Resident #1). On 12/10/25, Resident #1 complained of severe pain with the inability to move her ankle free in all movements. Resident #1 reported that she got her legs tangled when she got transferred. In reviewing Resident #1's clinical record her Kardex (a pocket Care Plan) instructed the staff to transfer her with the assistance of 2 staff and a full-body mechanical lift. The staff interviews determined the staff transferred Resident #1 at times without the full-body mechanical lift. The physician documented Resident #1 received her ankle fracture during a transfer. The facility reported a census of 43 residents.Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The MDS included diagnoses of heart failure, chronic kidney disease, muscle weakness, and difficulty walking. The Care Plan Task revised 8/21/25, documented Resident #1 required the use of a full-body mechanical lift with the assistance of 2 staff for transfers. The Kardex Report as of 12/1/25 indicated Resident #1 required assistance from 2 staff and the full-body mechanical lift.The Nurses Note documented 12/11/25 at 10:47 AM reflected the facility notified the physician about Resident #1's complaint of increased pain, swelling, and the inability to bare weight on her right ankle. The physician gave an order to get x-rays on the right ankle. An X-ray Report dated 12/11/25 at 1:33 PM, identified Resident #1 had a questionable right ankle fracture without dislocation.Review of Physician Progress Noted dated 12/15/25, indicated Resident #1 sustained an ankle fracture during a transfer. An interview on 2/5/26 at 11:49 AM, Staff A, Certified Nursing Assistant (CNA), stated at shift change Resident #1 sat on the commode. Resident #1 used her call light for assistance off the commode and transfer to the recliner. Staff A and Staff B, CNA, attempted to place the mechanical lift sling under Resident #1 to transfer her but couldn't. Instead of using the mechanical lift Staff A and Staff B attempted to manually transfer Resident #1 to the recliner. Staff A reported the transfer as very hard and awkward, adding it was a struggle. Staff A said they got tangled with Resident #1's legs. Staff A stated they (Staff A and Staff B) did get Resident #1 to the recliner. Staff A denied Resident #1 having a fall or complained of pain or discomfort. In an interview on 2/5/26 at 12:00 PM Staff B couldn't recall a time or incident transferring Resident #1 prior to finding the ankle injury. Staff B didn't believe she had been involved when Resident #1 may have received the injury. Staff B stated she knew of times other CNAs transferred Resident #1 without the use of the mechanical lift. In an interview on 2/5/26 at 12:50 PM Staff C, CNA, stated on 12/6/25 shortly before shift change (2:00 PM), Resident #1 told her she needed transferred to the commode quickly to avoid an accident. Staff C and Staff D, CNA, transferred Resident #1 with a two man transfer to the commode. An interview on 2/5/26 at 1:16 PM, Staff D, CNA, stated she was not sure if the injury happened when she had (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	assisted with Resident #1's transfer on 12/6/25. Staff D, CNA, stated almost every single one of us (CNAs) were doing a two-man pivot transfer, on that day (12/6/25) Resident #1 was fine when she was transferred to the commode, when Staff D, CNA, had returned to check on Resident #1, she had found Resident #1 had already been transferred from the commode to her recliner. A short time later, Resident #1 needed assistance with her pants, Staff D, CNA stated she helped stand Resident #1 pulling up her pants and adjusting her for comfort.Review of the facility's Investigation Summary dated 12/11/25 documented Resident #1 required the assistance of two staff and a mechanical lift for all transfers. On the morning of 12/11/25 Resident #1 reported having significant pain to her right ankle related to the transfer to her recliner after supper the previous night. Resident #1 her feet got tangled up when she went to her chair the night before. When questioning Resident #1 about her ankle, she responded she didn't want to hurt her feelings. On assessment Resident #1 could wiggle her toes and move her leg but couldn't flex her ankle joint. The facility's Investigation included a review of the staffing schedules, staff interviews, and statements that determined incidences of the CNAs assisting Resident #1 with a two-person transfer.Review of Facility Provided Safe Resident Handling/Transfers Policy and Procedure dated 2025 instructed the following:It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Mechanical lifting equipment or other approved transferring aids will be used based on the resident's needs to prevent manual lifting except in medical emergencies. Staff members are expected to maintain compliance with safe handling/transfer practices. Failure to maintain compliance may lead to disciplinary action up to and including termination of employment. Resident's lifting and transferring will be performed according to the resident's individual plan of care.