

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Oakview Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review and staff interviews, the facility failed to offer the COVID-19 (Coronavirus disease) vaccine for 5 of 5 residents reviewed (Residents #3, #21, #29, #39, and #45). The facility reported a census of 43 residents. Findings include: 1. Resident #3's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS indicated Resident #3 didn't receive an updated COVID-19 vaccine and lacked up-to-date status. Resident #3's Electronic Health Record (EHR) lacked documentation of vaccine receipt or a vaccine offer. On 7/15/26 at 9:55 AM, the Director of Nursing (DON) reported the facility should offer the vaccine at least annually. She reported she couldn't prove the facility offered the vaccine. The Influenza, COVID-19 and Pneumococcal Vaccination policy dated 2021 instructed the facility to offer the COVID-19 vaccination as recommended by the Centers for Disease Control (CDC) or the Iowa Department of Public Health. The CDC recommends updated vaccines for individuals vaccinated prior to the 2025-2026 vaccine to receive one or more doses. The guidelines further recommend everyone over the age of 6 months receive an updated COVID-19 vaccine. The Iowa Department of Health and Human Services (Public Health) recommends following the CDC guidelines. 2. Resident #21's MDS assessment dated [DATE] documented a BIMS score of 12, indicating moderately impaired cognition. The MDS indicated Resident #21 didn't receive an updated COVID-19 vaccine and lacked up-to-date status. Resident #21's EHR lacked documentation of vaccine receipt or a vaccine offer. 3. Resident #29's MDS assessment dated [DATE] documented a BIMS score of 15, indicating intact cognition. The MDS indicated Resident #29 didn't receive an updated COVID-19 vaccine and lacked up-to-date status. Resident #29's EHR lacked documentation of vaccine receipt or a vaccine offer. 4. Resident #39's MDS assessment dated [DATE] documented a BIMS score of 3, indicating severe cognitive impairment. The MDS indicated Resident #39 didn't receive an updated COVID-19 vaccine and lacked up-to-date status. Resident #39's EHR lacked documentation of vaccine receipt or a vaccine offer. 5. Resident #45's MDS assessment dated [DATE] documented a BIMS score of 13, indicating intact cognition. The MDS indicated Resident #45 didn't receive an updated COVID-19 vaccine and lacked up-to-date status. Resident #45's EHR lacked documentation of vaccine receipt or a vaccine offer.		

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. Based on record review, staff interviews and the Resident Assessment Instrument (RAI) manual the facility failed to complete the quarterly Minimum Data Set (MDS) assessment in the required timeframe for 1 of 1 residents reviewed (Resident #34). The facility reported a census of 43 residents. Findings include: Resident #34's Minimum Data Set (MDS) assessment report in the Electronic Health Record (EHR) documented completion of the last MDS assessment on 3/4/26. The MDS report showed the facility didn't complete the current quarterly MDS assessment. On 7/13/26 at 10:20 AM, the MDS Coordinator reported the tracking system in the EHR didn't exist, causing the facility to miss the quarterly MDS. On 7/13/26 at 10:24 AM, the Administrator reported staff should complete the MDS within the required timeframe. She reported the facility didn't have a policy for MDS assessments and followed the Resident Assessment Instrument (RAI) Manual. The RAI Manual dated October 2025 on page 2-17 instructed to complete the quarterly MDS every 3 months.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review and staff interview, the facility failed to identify a weight loss resulting in a failure to offer nutritional interventions, notify the Physician, Dietitian, or their family related to weight loss and poor intakes at meals for 1 of 1 resident reviewed (Resident #11). The facility reported a census of 43 residents. Findings include: Resident #11's Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS revealed Resident #11 ate independently. The MDS included diagnoses of Heart Failure (weakened heart), renal failure (kidney failure), and fatigue (extreme tiredness). Resident #11's Care Plan dated 1/6/26 documented a nutritional problem or potential nutritional problem related to a new environment, advancing age, and comorbidities (multiple medical conditions). The Care Plan documented the following interventions: Provide and serve diet as ordered. Monitor intake and record every meal. Registered Dietitian to evaluate and make diet change recommendations as needed. Weigh at the same time of day and record per facility policy. Resident #11's Care Plan lacked interventions related to low food intake identified on the current Care Plan since admission on [DATE]. The Weights and Vitals Summary obtained 7/16/26 showed the following weights since admission: [DATE]: 176.5 pounds (lbs.) 1/9/26: 175.0 lbs. 2/20/26: 183.5 lbs. 3/7/26: 173 lbs. 4/5/26: 175 lbs. 5/7/26: 176 lbs. 6/5/26: 174 lbs. 7/8/26: 161 lbs. 7/10/26: 160.5 lbs. Resident #11's Progress Notes lacked an assessment or communication with the physician, dietitian, or family regarding the weight loss noted in July 2026. Resident #11's current Order Summary Report didn't list the use of oral nutrition supplements or fortified foods. Resident #11's Meal Intakes from breakfast on 6/16/26 through breakfast on 7/15/26 documented Resident #11 ate 0-25% for 26 meals, 26-50% of 11 meals, refused 8 meals, and lacked documentation for 4 meals out of 88 total meals. On 7/15/26 at 10:20 AM, the MDS Coordinator reported any assessment or notification to the physician regarding a weight loss belonged in the progress notes. The MDS Coordinator reported finding no entries for Resident #11. On 7/15/26 at 10:50 AM, the Director of Nursing (DON) reported nurses should assess and notify the physician and family immediately when residents experience significant weight loss. The Assessment of Change of Condition dated 2023 instructed the 24-hour report serves as the major communication tool for reporting on residents, including weight changes. The policy further directed Licensed Nurses to complete a head-to-toe assessment, including full vital signs, and notify the attending physician, family, and DON.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and policy review, the facility failed to prevent cross-contamination during peri cares for 1 of 1 residents reviewed (Resident #2). The facility reported a census of 43 residents. Findings include: Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented Resident #2's impairment to both sides of the upper and lower extremities and total dependence on staff for toileting hygiene and dressing. The MDS included diagnoses of dementia (chronic memory loss) and stroke (blood clot or bleed in the brain). On 7/14/26 at 12:55 PM Staff B, Certified Nurses' Aide (CNA) and Staff C, CNA performed perineal care (cleaning of the private areas) on Resident #2. Staff B and Staff C completed hand hygiene and applied a gown and gloves. Both staff members gathered supplies and placed a barrier underneath Resident #2. Staff B and Staff C removed Resident #2's pants and incontinence brief. Staff B began cleaning Resident #2 from front to back. Staff B rolled Resident #2 onto the right side and used the same wipe multiple times. Staff B and Staff C rolled Resident #2 to the left side. During the turn, Staff B touched Resident #2's right hand with dirty gloves while adjusting the hand. Staff C began wiping Resident #2 from front to back using the same wipe multiple times. Staff C set the wipe down on the bed pad, folded it over, and used it again. Staff C repeated this action twice. Staff B then handed a clean brief to Staff C using the same dirty gloves used during the cleaning. Staff C, wearing the same dirty gloves from the care, placed the clean brief under Resident #2 on top of the bed pad where Staff C previously placed the dirty wipes. Staff B and Staff C rolled Resident #2 onto her back. Staff B began cleaning the front perineal area, wiping from front to back using the wipes multiple times. Staff B pulled the new brief up with the same dirty gloves, and both staff members secured it. Using the same dirty gloves, Staff B and Staff C pulled up Resident #2's pants. Staff B grabbed Resident #2's left hand with dirty gloves to adjust the arm onto the bed. Both staff members lifted Resident #2 up in bed, touched the bedsheet with dirty gloves, grabbed the blanket, and covered Resident #2. Staff B and Staff C removed the dirty gloves and completed hand hygiene. On 7/14/26 at 1:10 PM Staff B and Staff C acknowledged they didn't change their gloves between clean and dirty tasks. Both staff members confirmed touching multiple surfaces and Resident #2 with dirty gloves during the care. On 7/14/26 at 1:20 PM the Director of Nursing (DON) stated staff must change gloves between clean and dirty tasks. The Nurse Consultant (NC) stated staff must use wipes only one time. The Incontinent Care policy undated instructed staff to remove gloves after providing perineal care. The policy lacked directions instructing staff to use a wipe only once and change gloves between dirty and clean tasks.		