STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165439	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakview Nursing and Rehabilitation	1212 Indian Hills Drive Burlington, IA 52601

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 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. Based on observation, clinical record review, facility policy review, resident and staff interview, the facility failed to treat 1 of 6 residents (Resident #30) with dignity and respect when staff took more than an hour to assist with a transfer request made by a resident who required substantial assistance. The facility reported a census of 49 residents. Findings include: Review of the Minimum Data Set (MDS) assessment, dated 5/20/25, revealed Resident #30 scored a 13 out of 15 on the Brief Interview for Mental Status exam, which indicated intact cognition. The MDS indicated Resident #30 required substantial/maximal assistance with chair/bed to chair transfers. The MDS list of diagnoses included cerebral infarction (stroke). Review of the Care Plan, dated 12/30/24, revealed a Focus area to address Resident at risk for falling r/t (related to) falls prior to admit resulting in a L hip fx (left hip fracture). Interventions included, in part: a. Ax2 c GB and NMSA (assist of 2 with gait belt and non-mechanical standing aid), dated 12/30/24. b. Encourage resident to sit in day room, dated 5/30/25 c, Non-ambulatory, dated 6/13/25. During a continuous observation on 6/18/25 starting at 9:28 AM, Resident #30 seated in her recliner. Staff A, Certified Nursing Assistant (CNA) entered the room to pass water, and Resident #30 asked to be assisted from the recliner to her wheelchair. Staff A stated she would transfer Resident #30 in a little bit. At 9:44 AM, Staff A, CNA observed to have finished the water pass in the pod (the facility set up in pods, Staff A passed water on the pod where Resident #30 resided) and then went to the nurse's desk and spoke with nursing and rehab staff. At 9:48 AM, Staff A observed telling the Director of Nursing and Staff B, RN (Registered Nurse) she was going to help another resident with a puzzle. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 10:25 AM, Staff B, RN observed in Resident #30 room. Resident #30 remarked to Staff B she wanted to get into her wheelchair. Staff B told Resident #30 she would let the CNA know when they came back to the pod. Resident #30 remained in her recliner, with her feet elevated. During an interview on 6/18/25 at 10:29 AM, Resident #30 asked how her day was going and Resident #30 stated not good and nothing was going right. Resident #30 stated she was tired of people not listening to her and she just wanted moved to a different chair. Resident #30 stated it was disgusting and she was tired of being in the same chair and just wanted to get into her wheelchair. Resident #30 stated Staff B, RN was just in her room and she told Staff B she wanted into her wheelchair. Resident #30 stated staff B told her she would let the CNA know. At 6/18/25 at 10:36 AM, Staff A, CNA observed to be on the pod where Resident #30 resided, and then left. Resident #30 observed to be in her recliner. At 10:43 AM, Staff A, CNA returned to the pod and went into Resident #30 room with the non-mechanical lift and told Resident#30 she would get her up in a little bit. During an observation on 6/18/25 at 10:50 AM, Staff A, CNA knocked on Resident #30 door and asked if Resident #30 was ready and Resident #30 asked ready for what. Staff A stated it was about lunch time and asked if Resident #30 needed to use the bathroom. Staff A and another CNA went into the room and closed the door. At 10:54 AM, the door to Resident #30's room opened, and Resident #30 observed sitting in her wheelchair. During an interview on 6/18/25 at 1:20 PM, Staff A, CNA queried on how Resident #30 transferred and Staff A stated Resident #30 required an assist of 2 with the non-mechanical lift. Staff A asked how long a resident should wait to be transferred. Staff A stated it depended on if the non-mechanical lift was being used. Staff A stated they only had one non-mechanical lift for all 3 pods. Staff A asked about this morning and Staff A stated she went over to C pod and grabbed it [non-mechanical lift]. Staff A queried about Resident #30's request to move from her recliner to her wheelchair, and she stated Staff B, RN told her and it only took a couple of minutes to go and get the non-mechanical lift. Staff A queried about when Resident #30 asked Staff A to move during the water pass, and she stated she told Resident #30 in a little bit. Staff A explained Resident #30 had just gotten into her recliner. When asked how long a resident should wait to be assisted with a transfer, Staff A answered 5 or 10 minutes, if that. During an interview on 6/19/25 at 10:53 AM, Staff B, RN stated Resident #30 transfers with an assist of 2 with a non-mechanical lift. When asked if Resident #30 asked to be moved to her wheelchair, Staff B stated yes, just like Resident #30 did today. Staff B stated Resident #30 would stay in her wheelchair all day if Resident #30 could, but Resident #30 needed a position change. Staff B informed Resident #30 requested to be moved during water pass and Staff B stated staff just got Resident #30 in the recliner after breakfast. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/23/25 at 3:39 PM, the DON informed of the observation and the DON stated that was not right and when water pass was completed, Resident #30 should have been moved. The DON stated staff need to give the residents a time frame of when they will come back. The DON asked what if the Resident had just transferred to the recliner 10-15 minutes prior and the DON stated if the resident wanted moved, move them and it was always good to reposition. Review of the facilities Resident's [NAME] of Rights Policy, revised on 12/2023, revealed the following: a. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Review of the MDS assessment for Resident #18, dated 4/8/25 revealed the resident scored 12 out of 15 on a BIMS exam, which indicated moderate impaired cognition. Per the assessment, the resident received antidepressant medication. Review of Resident #18's Care Plan revealed an undated Focus area to address Resident receives psychotropic antidepressant medication related to depression. Undated Interventions included, in part: Review continued need for medication with prescriber, attempt dose reduction as warranted. Review of Resident 18's Clinical Physician Orders for Sertraline (antidepressant) revealed the resident had been on Sertraline 50 milligrams (mg) since 2/24/2024. Review of the the Pharmacy Review Note, dated 9/29/24, revealed the following documentation: MRR - GDR. The clinical record lacked documentation of any other GDR in the last 12 months (6/1/24 to 6/18/25). On 6/18/25 at 3:40 PM, Resident #18's GDR, dated 9/29/24, requested via email from the facility's Administrator. On 6/19/25 at 11:15 AM, in a response via email, the Administrator reported that she was still working on trying to locate the GDR for Resident #18. On 6/19/25 at 12:22 PM, the Administrator emailed a GDR completed by the pharmacist and signed off by the Advanced Registered Nurse Practitioner (ARNP), dated 6/19/25, which indicated a GDR was contraindicated at this time. The facility failed to provide documentation related to the GDR recommendations, dated 9/29/24. Based on observation, interview, and record review, the facility failed to ensure timely Physician follow up to requests for Medication Regimen Review (MRR) and Gradual Dose Reduction (GDR) and failed to ensure rationale provided for declination of GDR for 4 of 5 residents (Resident #17, Resident #18, Resident #26, Resident #40) reviewed for unnecessary medications The facility reported a census of 49 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment for Resident #17 dated 5/8/25 revealed the resident scored 5 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per the assessment, the resident received antipsychotic, antidepressant, opioid, antiplatelet, and hypoglycemic medications. Review of Resident #17's Physician Order dated 8/23/24 revealed, Seroquel Oral Tablet 25 MG (milligram) with directions to give 1 tablet by mouth at bedtime related to Alzheimer's Disease. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #17's Physician Order dated 4/7/22 revealed, Sertraline HCl Tablet 50 MG with directions to give 1 tablet by mouth one time a day related to Alzheimer's Disease. Review of Resident #17's Note to Attending Physician/Prescriber printed 1/31/25 revealed the Pharmacist recommended a GDR for the resident's Seroquel Oral Tablet 25 MG (milligram), an antipsychotic medication, and for Sertraline HCL Oral Tablet 50 MG, an antidepressant medications. Review of the the Pharmacy Review Note dated 1/31/25 at 3:39 PM revealed, MRR - GDR. On 6/18/25 at 12:23 PM, Resident #17's GDR dated 1/31/25 requested via email from the facility's Administrator. On 6/18/25 at 2:17 PM, the Administrator response to the email request explained - for January [1/31/25] we are unable to locate a signed copy. 2. Review of the MDS assessment for Resident #40 dated 3/20/25 revealed the resident scored 15 out of 15 on a BIMS exam, which indicated intact cognition. Per the assessment, the resident received antianxiety, antidepressant, hypnotic, antibiotic, diuretic, opioid, and hypoglycemic medication. Review of Resident #40's Medication Administration Record (MAR) dated September 2024 revealed the resident took the following antidepressant medications: Amitriptyline 25 MG at bedtime started on 10/8/23, Mirtazapine 15 MG at bedtime started on 10/6/23, Trazodone 100 MG at bedtime started on 12/4/23, and Trazodone 25 MG started on 6/14/24. Per the MAR, the resident took the following anxiety medication: Buspirone 30 MG twice a day started on 10/10/23. The MAR further revealed the resident took the following hypnotic medication: Zolpidem Tartrate 5 MG at bedtime. Review of the Pharmacy Review Note dated 9/29/24 at 3:03 PM revealed, MRR - GDR amitriptyline, mirtazapine, buspar, trazodone, zolpidem. The Pharmacy Review Note dated 12/29/24 at 7:47 PM revealed, MRR - GDR - Repeating September GDR request as pharmacy did not receive response. Please verify in paper chart that documentation is present and resend. Patient also has MRSA (Methicillin-resistant Staphylococcus aureus) listed as the dx (diagnosis) for three times weekly azithromycin, please ensure that this is the correct diagnosis and update it. Thanks! On 6/23/25 at 11:12 AM, the facility's Administrator provided GDR recommendations from the Pharmacist dated 9/30/24, 12/31/24, and and 4/1/25. The Administrator explained via email that the GDRs were not addressed. On 6/23/25 at 1:53 PM, the Administrator provided the GDR dated 4/1/25, which revealed a response documented on 6/23/25. 4. Review of the MDS assessment dated [DATE] revealed Resident #26 scored a 15 out of 15 on the BIMS exam, which indicated intact cognition. The MDS indicated resident received antidepressant and antianxiety medications. Review of the electronic health record revealed the following Physician Orders: Clonazepam oral tablet 0.5 mg (milligrams) give 1 tablet by mouth at bedtime every other day started 11/16/23, Trazodone HCl (hydrochloride) oral tablet give 25 mg by mouth at bedtime started 11/16/23, and Sertraline HCl tablet 100 mg- give 1 tablet by mouth one time a day started 5/17/23 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Pharmacy Review Note dated 9/29/24 at 4:25 PM, revealed MMR (Monthly Medication Review)- GDR clonazepam, sertraline, trazodone. The Note to Attending Physician/Prescribed printed on 9/30/24 revealed a GDR for clonazepam oral tablet 0.5 mg, trazodone 25 mg oral tablet, and sertraline 100 mg oral tablet. The facility lacked documentation the provider addressed the GDR recommendation. The Pharmacy Review Note dated 12/29/24 at 4:08 PM, revealed revealed MMR-GDR. The Note to Attending Physician/Prescribed printed on 12/31/24 revealed a GDR for clonazepam oral tablet 0.5 mg, trazodone 25 mg oral tablet, and sertraline 100 mg oral tablet. The facility lacked documentation the provider addressed the GDR recommendation. The Pharmacy Review Note dated 5/29/25 at 11:31 PM, revealed MMR-GDR. The Note to Attending Physician/Prescribed printed on 6/4/25 revealed a GDR for clonazepam oral tablet 0.5 mg. On 6/18/25, the provider checked to maintain current dose without a rationale documented. Per the email from the Administrator on 6/23/25 at 11:04 AM, Resident #26 GDRs were not addressed. During an interview on 6/23/25 at 3:37 PM, the Director of Nursing (DON) queried on the process of the GDRs and the DON stated they reached out to the doctor about them and see if the GDR was needed. The DON asked what the facility did when the GDRs were not addressed and the DON stated they requested again or took them to the Medical Director. The DON queried about the provider not putting a rationale when a GDR declined and the DON stated [name redacted] didn't put the reasoning and there was currently a Performance Improvement Project (PIP) on [name redacted] to do the GDR the right way. The DON confirmed Resident #26 GDRs for September and December were not addressed and the facility was going to have the Nurse Practitioner do them because the Nurse Practitioner was more thorough. Review of the Facility Policy titled Drug Regimen Review, Monthly dated 11/28/17, revealed the following: Upon identifying any irregularity, pharmacist will provide a written report addressing the drug irregularities to the attending provider, the facility medical director, and the director of nursing. Attending provider's response will be documented in the resident's medical record indicating the identified irregularity has been reviewed and what, if any, action has been taken. If no change in medication, attending physician must document rationale in the medical record. Irregularities identified by the pharmacist that require urgent action to protect the resident will be immediately reported to the director of nursing or nurse in charge who will then notify the attending provider. The Facility Use of Psychotropic Medications Policy dated 4/28/25 for the following: a. Residents who use psychotropic drugs shall receive gradual dose reductions, unless clinically contraindicated in an effort to discontinue these drugs.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, resident and staff interview, the facility failed to offer the pneumococcal vaccine to 3 of 5 residents (Residents #23, #36, and #40) reviewed for immunizations. The facility reported a census of 49 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment, dated 4/24/25, revealed Resident #23 list of diagnoses included respiratory failure and lung cancer. The Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicated intact cognition. The MDS listed an admission date of 4/8/24, and over the age [AGE]. Review of the Vaccination Consent Form, signed 4/8/24 by Resident #23, documented the resident had never received the Pneumovax (PPSV23) vaccine or any of the pneumococcal conjugate vaccines, Prevnar 13 (PVC13), Prevnar 20 (PVC20), or Vaxneuvance (PVC15). The resident consented to receive the pneumococcal vaccination on 4/8/24. On 6/17/25, review of the clinical record revealed a lack of documentation that Resident #23 had received any form of the pneumococcal vaccine. On 6/18/25 at 2:40 PM, the Administrator sent an email response which identified the resident did not receive the pneumococcal vaccine. During an interview on 6/18/25 at 3:50 PM, the Administrator reported Resident# 23's family member had consented to the vaccine for the resident and staff had not followed through with getting an order for the pneumococcal vaccine. The family member still wanted the vaccine administered when they contacted them today (6/18/25). The Administrator reported facility staff got an order from the resident's physician to administer the vaccine. 2. Review of the MDS assessment, dated 4/15/25, revealed Resident #40 list of diagnoses included of acute and chronic respiratory failure, and chronic obstructive pulmonary disease. The BIMS score of 13 out of 15 indicated intact cognition. The MDS listed an admission date of 10/6/23, and over the age of 65. Review of Resident #40's immunization record revealed the resident had received Prevnar 13 (PVC13), dated 4/24/17 and Pneumovax (PPSV23), dated 8/28/18, and had not received one of the following immunizations 5 years after (since 8/28/23) Pneumovax (PPSV23): PCV15, or PCV20, or PCV21 (pneumococcal conjugate vaccine). Review of the Pneumococcal Immunization Informed Consent form, signed and dated 10/6/23 by Resident #40, documented the reason the resident refused the pneumococcal conjugate was due to already received. The clinical record lacked documentation the resident had received the PCV15, or PCV20, or PCV21 vaccine. The clinical record lacked documentation facility staff had offered the PCV15, or PCV20, or PCV21 vaccine in 2024 or 2025. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/25 at 6:28 PM, the Administrator sent an email with a signed and dated consent form, dated 6/18/25, for Resident #40 to receive the pneumococcal vaccine. During an interview on 06/19/25 at 8:55 AM, Resident #40 reported she had been offered the pneumococcal vaccine on admission to the facility, but had refused. Resident #40 thought she had been offered the vaccine last year. Resident #40 reported she was offered the pneumococcal vaccine today (6/19/25). 3. Review of the MDS assessment, dated 3/13/25, revealed Resident #36 list of diagnoses included iron deficiency anemia, moderate intellectual disability and history of venous thrombosis and embolism (blood clot). The BIMS score of 2 out of 15 indicated a severe cognitive impairment. The MDS listed an admission date of 7/13/22, and over the age of 65. Review of Resident #36's immunization record revealed the resident had received the Pneumovax (PPSV23) vaccine, dated 8/11/22, and had not received one of the following immunizations: PCV15, or PCV20, or PCV21 (pneumococcal conjugate vaccine) at least 1 year after the last PPSV23 dose. The clinical record lacked documentation facility staff had offered a pneumococcal conjugate vaccine once the resident became eligible on 8/11/23. Review of the Vaccination Consent Forms, signed 9/23/24 by Resident #36's guardian, documented the guardian consented to the resident to receive the Influenza, COVID and Respiratory Syncytial Virus (RSV) vaccinations. The record lacked documentation facility staff offered the resident's guardian the choice of consenting or refusing the pneumococcal conjugate vaccine for the resident. During an interview on 06/18/25 at 12:00 PM, the Director of Nursing (DON) reported she had been in her role as the Infection Preventionist about one year. The DON explained she was responsible for educating and offering residents vaccinations. The DON explained she tracked immunization through the electronic health record and ran a report to identify when residents were due for immunizations. During an interview on 06/19/25 at 8:33 AM, when asked about the knowledge the DON had about the pneumococcal vaccine schedule, she explained she just recently learned how to determine when the pneumococcal vaccines were due. The DON clarified that she just learned the pneumococcal vaccine schedule a couple weeks ago. The DON reported she followed the Center for Disease Control (CDC) chart for determining when residents were due for the pneumococcal vaccine, and used the chart to provide education to residents and their family. The DON explained that she had not had a chance to run the reports in the electronic health record (EHR) to determine who should have been offered the pneumococcal vaccine since learning when the vaccinations should be offered. The DON reported she did not run a report until yesterday (6/18/25) in the EHR on Resident #40 after the surveyor asked about the pneumococcal vaccine. The DON explained that she identified from the EHR report that Resident #40 was due to be offered the pneumococcal conjugate vaccine (PCV15, or PCV20, or PCV21) and obtained the consent from Resident #40 to administer the medication. The DON reported that Resident #36 was also due for the pneumococcal conjugate vaccine, and staff was calling the POA (Power of Attorney) right now to see if POA wants Resident #36 to have it. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy, titled Pneumococcal Vaccinations, dated 9/12/24, revealed facility staff would assess all persons, upon admission, for receiving a pneumococcal polysaccharide vaccine and/or pneumococcal conjugate vaccine and follow CDC recommendations. Staff would administer PCV15, PCV20, or PCV21 for all adults 65 years or older whether the resident had received PVC13 at any age and PPSV23 at or after the age of 65 years. Per CDC guidelines: if a person previously received both PCV13 and PPSV23, AND PPSV23 was received at age [AGE] years or older, based on shared clinical decision-making, 1 dose of PCV20, or 1 dose of PCV21 administered at least 5 years after the last pneumococcal vaccine dose. If the person previously received only PPSV23: then 1 dose PCV15, or 1 dose PCV20, or 1 dose PCV21, at least 1 year after the last PPSV23 dose.