

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165626	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Oakview Nursing & Rehabilitation - Marion		STREET ADDRESS, CITY, STATE, ZIP CODE 720 Oakbrook Drive Marion, IA 52302	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34821</p> <p>Based on observation, clinical record review, staff and resident interviews the facility failed to prevent one resident from wandering into another resident room and putting their hand on a resident for 1 out of 6 residents reviewed (Resident #1). The facility reported a census of 29 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE], listed diagnoses of non-Alzheimer's dementia, and stroke. The Brief Interview for Mental Status (BIMS) score of 0 (severe cognitive impairments). The MDS revealed Resident #1 showed verbal and physical behavior towards others on 1-3 days of the look back period. The MDS reflected Resident#1 wandered 2-6 days in the look back period.</p> <p>The Care Plan dated 3/11/25, identified Resident #1 had impaired cognition related/to dementia. Cue, reorient and supervise as needed.</p> <p>The Care Plan dated 3/14/25, identified Resident #1's physical and verbal behavioral symptoms toward others (e.g. hitting, kicking, pushing, scratching). The Care Plan listed a goal that Resident #1 not harm others secondary to physically aggressive behavior.</p> <p>The Care Plan dated 3/14/25, revealed Resident #1 experienced wandering. He will wander safely within specified boundaries. The interventions included: Remove resident from other resident's rooms and unsafe situations.</p> <p>The CAA Worksheet dated 3/14/25, triggered communication identified Resident #1's severe dementia which inhibits his ability to understand others and make himself understood. At baseline, resident resided in a memory care and required assistance with activities of daily living (ADL) and decision making. Resident required interventions focused at dementia vs. communication deficits.</p> <p>The CAA Worksheet dated 3/14/25, reflected Resident #1's behavioral symptoms include physical aggressiveness, verbal, and wandering (see electronic health record documentation from 3/6/25 to 3/13/25). Resident #1's severe dementia that limits ability to understand others and self. He required assistance with ADL's and mobility.</p> <p>The Medication Administration Record (MAR) dated 3/2025, directed check wander guard placement every shift for wandering.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Progress Note dated 3/7/2025 at 2:09 PM, identified Behavior Note, Resident #1 self-transferring to different chairs in the living room. Shortly after found ambulating down the hall by himself and into public bathroom. Staff assisted and able to redirect him to living room after using the toilet.</p> <p>The Progress Note dated 3/8/2025 at 9:51 PM, reflected Resident #1 needed a lot of attention today. Staff walked resident often, found activities for him and 1 on 1. He often wanted to get up without assistance. If not approached carefully he can easily get mad/aggressive.</p> <p>The Progress Note dated 3/9/2025 at 9:50 AM Resident #1 up on own often and if aggressive/behaviors one assist is necessary sometimes. Extra staff over stimulate him, he gets physical et balance is worse. no aggression yet today.</p> <p>Review of the POC Response History for Resident #1 dated 3/2025, showed behaviors on 7 out of days 13 that included hitting/kicking, pushing, grabbing and wandering 9 out of 13 days.</p> <p>The Minimum Data Set (MDS) assessment for Resident #3 dated 2/3/25, listed diagnoses of Multiple Sclerosis, high blood pressure, and malnutrition. The BIMS reflected a score of 15 (intact cognition). The MDS identified Resident #3 required substantial/maximal assistance with upper body dressing, rolling in bed and dependent on staff for lower body dressing, toileting hygiene, and chair to chair transfer.</p> <p>The Care Plan for Resident #3 dated 1/6/25, identified she's non-ambulatory and transferred with the assist of 2 staff and a full boy lift.</p> <p>Observation on 3/24/25 at 1:00 PM, Resident #3 laid in her bed with the head of the bed up approximately 30 degrees, covered with her blankets. The tray table next to her with her items of choice on top of it. Her call light secured to the grab bar to her left.</p> <p>During an interview on 3/24/25 at 1:00 PM, Resident #3 reported Resident #1 entered her room [ROOM NUMBER] times last week. She stated the 1st two times he came in her room he wandered and looked at her things. She said the 3rd time he came in and closed the door, he used one of her stuffed animals to dust the art on the walls. She revealed she thought he may break something. Resident #3 stated then he came over to her while she laid in the bed and tapped her lap and groin like a set of Bongos. Resident #3 reported he pulled on the blankets however they were tucked under her tray table and he couldn't get them to move far. She reported he'd seemed confused and talked nonsensical. She reported she told him to get out several times. She reported as soon as he came in her room she turned on the call light and the Staff A, Certified Nurse Aid (CNA) came and escorted him out of her room. She reported she's not sure how long it took the staff to come, 10, 15, 20 minutes. Resident #3 revealed Resident #1 hit Staff A several times while she took him out of her room. Resident #3 reported she feared he may break her things, and she failed to know what his intention were. She revealed she felt he failed to know his intentions as well.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/25/25 at 2:55 PM, Staff A, reported on 3/19/25 on the evening shift around bedtime Resident #1 went into Resident #3's room and touched her things. She reported and she got him out of her room, and told Resident #3 she would try to keep an eye on him. Staff A said she went and helped another resident to bed. Staff revealed when she came out that room the wife of another resident alerted her that Resident #1 entered Resident #3's room again. Staff A reported she ran to Resident #3's room as she entered the room she saw Resident #1 stood on the right side of Resident #3's bed while his hand sat on her mattress. She reported she removed Resident #1 from the room and told Staff D, Licensed Practical Nurse (LPN) that Resident #1 wandered into Resident #3's room again. Staff A, reported Resident #3 seemed upset that Resident #1 entered her room and touched her things. She stated she reported to the nurse that he got up on his own daily and would wander.</p> <p>During an interview on 3/25/25 at 3:05 PM, Staff B, CNA, stated she reported to the nurses that Resident #1 got up on his own daily and would wander. She reported they failed to keep an eye on him all the time due to caring for other residents. Staff B, stated she thought he needed more supervision to keep him safe. She said Resident #1 hit at the staff sometimes.</p> <p>During an interview on 3/25/25 at 3:45 Staff D, Licensed Piratical Nurse (LPN) reported Resident #1 wandered on the Unit. She knew in the last week he lived here he went into Resident #3's room a few times and messed with her things. She stated on one of the last evenings he lived here a CNA paged her to come help her get him out of Resident #3's room. Staff D reported they did they best they could to keep an eye on him and keep him out of another residents' space. She reported he got resistive with the CNAs when they redirected.</p> <p>During an interview on 3/26/25 at 1:00 PM, the Director of Nursing (DON) reported Resident #1's wandering consisted of walking around and looked at things. She reported the wandering appeared aimless. The DON stated Resident #3 requested her to come and talk to her on 3/20/25. The DON reported Resident #3 told her Resident #1 went into her room, touched her things then went over to her and pulled on the extra cover she always placed on her chest/abdomen. The DON stated Resident #3 said she knew Resident #1 lacked a purpose in the room. The DON revealed she lacked a concern for Resident#1 entering Resident #3's room. She reported he's never shown aggressive behavior to other residents. She acknowledged behaviors to the staff. The DON acknowledged the Care Plan addressed aggressive behaviors. The DON denied knowledge of Resident #1 tapping Resident #3 like a Bongo. The DON denied any knowledge Resident #1 entered her room the day before or earlier on the shift. The DON stated she communicated this situation with the Administrator and the consulting company.</p> <p>On 3/26/25 at 1:35 PM, the Administrator reported the facility failed to have a separate policy for resident to resident incidents. She reported it's covered on the Incident Report policy.</p> <p>The facility provided a policy titled Incident Report Completion of dated 8/10/18, directed a written report shall be maintained on any incident or unusual incident involving residents, visitors, employees or agency staff, occurring within the facility or on the premises.</p> <p>An incident report shall be initiated for any unusual incidents involving residents whether they occur at the facility or not, whether injury is apparent or not.</p> <p>Unusual incidents include but are not limited to:</p> <p>-Resident to resident physical aggression or verbal threat (complete a report for each</p> <p>(continued on next page)</p>		

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