STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165626	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakview Nursing & Rehablitation - Marion	720 Oakbrook Drive Marion, IA 52302

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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 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** 44972 Based on observation, record review, staff interview, and policy review, the facility failed to ensure dignity was provided to residents with catheters by not placing the catheter bags in dignity bags for 2 of 4 residents reviewed for catheters (Residents #8 and #143). The facility reported a census of 39 residents. Findings include: 1. A Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 had a Brief Interview for Mental Status (BIMS) of 13 indicating intact cognition. The MDS further documented the resident had diagnoses including neurogenic bladder, chronic kidney disease, congestive heart failure, and diabetes mellitus. The resident required assistance of staff for toileting, personal hygiene, bathing, and transfers. She had an indwelling catheter and was frequently incontinent of bowel. The Care Plan dated 7/3/24 revealed a focus area for Resident #8's need for an indwelling urinary catheter related to a neurogenic bladder with a goal the resident's catheter care would be managed appropriately to prevent signs of infection or urethral trauma. Interventions included: assessing for continued need for the catheter at least quarterly, providing catheter care twice a day and as needed, and the use of a catheter strap. In an observation on 8/13/24 at 7:43 AM, Resident #8 was noted to be lying in bed and the catheter bag was hanging from the bed frame and not in a dignity bag and visible to staff, residents, and visitors that may pass by in the hallway. In an observation on 8/13/24 at 8:30 AM, Resident #8 was noted to be lying in bed and the catheter bag was hanging from the bed frame and not in a dignity bag and visible to staff, residents, and visitors that may pass by in the hallway. In an observation on 8/13/24 at 10:15 AM, Resident #8 noted to be sitting in the recliner in her room and the catheter bag was hanging from the recliner and not in a dignity bag. In an observation on 8/14/24 at 8:03 AM, Resident #8 noted to be sitting in the recliner in her room and the catheter bag was hanging from the recliner and not in a dignity bag. (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	2. An initial MDS assessment was not completed for Resident #143 related to this resident admitting on 8/1/24 and discharging to home on 8/13/2 prior to completion of the MDS. Resident #143 carried diagnoses of atrial fibrillation, diabetes mellitus, chronic kidney disease, neuromuscular dysfunction of the bladder, multiple sclerosis, and epilepsy. The baseline Care Plan dated 8/3/24 indicated Resident #143 was alert and oriented. The resident required set up assistance with eating, the assistance of 1 staff for personal hygiene and the assistance of 2 staff for bed mobility, transfers, toileting, and bathing. Resident #143 had a Foley catheter. Resident was independent with mobility in an electric wheelchair. In an observation on 8/12/24 at 1:34 PM, Resident #143 noted to be seated in his electric wheelchair in his room with the catheter bag hanging from the elevated leg rest and not in a dignity bag. It was visible to staff, residents, and visitors that may pass by in the hallway. In an observation on 8/13/24 at 8:05 AM, Resident #143 noted to be seated in his electric wheelchair in his room and the catheter bag was hanging from the electric wheelchair and not in a dignity bag and visible to staff, residents, and visitors that may pass by in the hallway. In an observation on 8/13/24 at 12:11 PM, Resident #143 noted to be seated in his electric wheelchair at a table in the dining room for lunch and the catheter bag was hanging from the electric wheelchair and not in a privacy bag. The bag was visible to any staff, residents, and visitors that may have come by. In an interview on 8/15/24 at 8:48 AM, the Director of Nursing (DON) stated it was the expectation that dignity bags be used on urinary catheter bed bags when in the community environment and the staff were educated they only had to be used in the community areas. A facility provided Policy titled Catheter Care effective on 10/1/18 stated the catheter bag must be covered with a dignity cover when in a public area.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 35434 Based on clinical record review, policy review, and staff interviews, the facility failed to ensure residents remained free of physical abuse when a staff member hit a resident on the shoulder for 1 of 1 residents reviewed for abuse(Resident #23). The facility reported a census of 39 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 6/13/24, listed diagnoses for Resident #23 which included diabetes, non-Alzheimer's dementia, and morbid obesity. The MDS stated the resident required substantial to maximal assistance for dressing and was dependent on staff for toileting hygiene, showering, and transfers. The MDS listed the resident's Brief Interview for Mental Status Score (BIMS) as 6 out of 15, indicating severely impaired cognition. The Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, dated July 2019, stated all residents had the right to be free from abuse and defined physical abuse to include hitting and slapping. Care Plan entries, dated 1/30/23, stated the resident had verbal behavioral symptoms directed toward staff (yelling, name calling) and directed staff to: avoid power struggles with the resident. convey an attitude of acceptance toward the resident. maintain a calm environment and approach to the resident. offer the resident a soda. refocus the conversation when the resident became verbally abusive. A 4/14/23 Care Plan entry stated the resident had a mood problem related to Neurocognitive disorder (a disorder which can affect cognitive abilities). A 3/26/24 Care Plan entry directed staff to redirect the resident's behavior and stated if the resident was resistive to cares, leave him alone and attempt again in a few minutes. A statement written by Staff C, CNA (Certified Nursing Assistant) on 8/5/24 stated as staff helped the resident lie down after his shower at 1:45 p.m., Staff A CNA argued with the resident and he hit her. Staff A then punched the resident in the left shoulder and said to him if you punch me then I will punch you and next time I'll give you a black eye and tell everyone I don't know how it happened. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A statement written by Staff A on 8/5/24 stated she helped to put Resident #23 in his chair when he tried to hit her in the chest. She told him to stop trying to hit her and told him that was why [name redacted] was with [name redacted]. A statement written by Staff B CNA on 8/5/24, stated she entered Resident #23's room and he was set up to transfer with Staff A and Staff C. Staff B entered the room and ran the machine. After the transfer, Staff B exited the room and did not witness anything. An 8/5/24 Incident Report stated a shower aide reported that she and another CNA assisted a resident to lie down at approximately 1:45 p.m. and the resident and the other CNA began arguing. The resident then hit the CNA and the CNA punched the resident in the left shoulder. On 8/13/24 at 2:29 p.m., Staff C CNA stated she, Staff A, and Staff B assisted the resident to transfer with the mechanical lift. She stated Staff B ran the lift and she(Staff C) was on the resident's right and Staff A was on the resident's left. Staff C stated the resident and Staff A argued and the resident stated that Staff A didn't like him. Staff C stated Staff A told the resident that his wife didn't love him and cheated on him with [name redacted]. Staff C stated then the resident hit Staff A but she did not see where. Staff C stated Staff A then hit the resident in the left shoulder. She stated the hit was hard enough she could hear it. Staff C stated Staff A then said if he hit her, she would punch him back and next time she would punch him in the face and give him a black eye. Staff C stated she did not observe any red marks on the resident's shoulder after the hit. On 8/15/24 at 4:09 p.m., Staff C stated when Staff A hit the resident she had a closed fist. She stated the hit was not in response to the resident hitting Staff A but occurred after that. On 8/14/24 at 12:56 p.m. Staff A CNA stated on the day of the incident as she lifted the resident up in the mechanical lift, he tried to strike her but she stepped back and his hit did not connect. She stated she put her hand up and blocked his hit and they connected at the forearms. She stated if she had not put her hand up to block him, he would have hit her in the chest. She stated she told the resident that was why [name redacted] was with [name redacted-the resident's wife]. She stated there was no meaning behind this and she said this to try to be funny. Staff A denied that she hit the resident and stated the only thing she was guilty of was making this comment. On 8/15/24 at 10:08 a.m., the Administrator stated she expected staff to treat residents with respect and dignity and to go above and beyond.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 35434 Based on observation, policy review, and staff interview, the facility failed to hold hot foods at an adequate minimum temperature for 1 of 1 meal service observed. The facility reported a census of 39 residents. Findings include: The 2/24 facility Dietary Policies and Procedures with the subject of Food Temperatures stated the minimum temperature of hot foods was 135 degrees Fahrenheit. On 8/13/24 at 12:29 p.m., Staff D Dietary Aide served the last meal in the B Wing. Immediately after the service, he obtained the following temperatures: Sweet potatoes 119 degrees Fahrenheit Green Beans 120 degrees Fahrenheit Pork 130 degrees Fahrenheit. Pureed meatballs 96 degrees Fahrenheit. Pureed sweet potatoes 99 degrees Fahrenheit. Gravy 90 degrees Fahrenheit. Pureed green beans 108 degrees Fahrenheit. On 8/14/24 at 9:51 a.m. the Dietary Manager stated hot food should be held at a minimum temperature of 135 degrees Fahrenheit. She stated she stood around the corner while Staff D obtained the temperatures on 8/13/24. She stated the facility would order more lids and cover the food in order to ensure adequate hot holding temperatures.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35434 Based on observation, policy review, and staff interviews, the facility failed to store and prepare food under sanitary conditions for 3 of 3 kitchen areas reviewed. The facility reported a census of 39 residents. Findings include: The facility undated [name redacted(name of detergent company)] Detergent Services policy stated (dishwasher) rinse temperatures should reach between 176 degrees Fahrenheit to 185 degrees Fahrenheit. The 2/24 facility Dietary Policies and Procedures with the subject of Good Safety and Sanitation Guidelines stated the facility would utilize the current food code for standards of practice for the dietary department to meet the needs of safe food handling and sanitation of the kitchen. The 2/24 facility Dietary Policies and Procedures with the subject of Personal Hygiene stated food service employees must wear a hair restraint to effectively keep hair from coming in contact with exposed food or clean equipment. The facility 8/14/24 Kitchenette Daily Cleaning List included direction for staff to clean the microwave and refrigerator. The initial main kitchen tour on 8/12/24 at 9:38 a.m., revealed the following concerns: The dishwasher had a thick brown substance on the top of the side panels of the machine. A vent on the ceiling above the dishwasher had dust particles hanging from it. The vent was located above and in close proximity to the location clean dishes exited the dishwasher. Dust particles hung from 3 spigots of the fire suppression system, located directly above stove burners. Multiple boxes in the walk-in freezer covered with thick ice which appeared to come from melted water. The Dietary Manager stated the freezer broke recently and reached in and took out a round object covered with ice. She did not discard the other ice-covered boxes. Observations of the main kitchen on 08/13/24 at 9:58 a.m. revealed the following concerns: Dust-like particles covered a shelf which held spice containers. Dust remained on the fire suppression system spigots. 2 covered pots sat under the spigots on the stove burners. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	White food debris was present under the microwave and all 6 interior walls were covered with food debris and splatters. The hinges of the door also contained pieces of food debris. The outside of the microwave was covered with greasy looking finger prints. Brown food debris and fingerprints covered the outside control panel of the commercial toaster. Cooking oil bottles sat on a tray covered with multiple crumbs. Dust remained on the ceiling vent above the dishwasher. Multiple ice-covered boxes remained in the walk-in freezer. The Dietary Manager stated the round object she removed yesterday was sugar cookie dough and stated the ice covered boxes which remained included boxes containing 120 cinnamon rolls, crab, and turnovers. She stated these needed removed but she did not have time yet. Observations of the B Wing Kitchenette on 8/13/24 at 11:56 a.m. revealed the following concerns: The second cupboard from the right contained a spilled red liquid in contact with blue plastic lids. The floor of the second left lower cupboard contained onion skins and crumbs. Bowls sat on a plastic sheet of an upper cupboard. Crumbs and what appeared to be an eyelash were present on the plastic sheet. The sides of the door and the interior top of the dishwasher had a white build-up approximately 2 inches thick. Clean dishes were present in the dishwasher in close proximity to the buildup on the sides of the doors and on the top of the interior dishwasher. Fingerprints and splatters were present on the outside of the oven. Two staff members without hair nets entered the kitchenette and washed their hands during the noon meal service. Staff D Dietary Aide placed a disc thermometer into the dishwasher and ran a cycle. Upon completion of the cycle, the thermometer read a maximum temperature of 149 degrees Fahrenheit. Staff E [NAME] stated he would contact the dishwasher company. A toaster sat in a pile of crumbs on a bottom shelf. Staff D stated he utilized the toaster every day. All 6 interior walls of the microwave were covered with brown splatters and the outside of the microwave was sticky to the touch. Observations of the C Wing kitchenette on 8/14/24 at 9:03 a.m. revealed the following concerns. The outside of the dishwasher contained a brown build-up. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dish racks sat in a thick layer of crumbs and pieces of food in a lower cupboard. All 6 interior walls of the microwave were covered with food debris and brown splatters. Plastic cup lids were wet and sat in crumbs in a drawer. Brown splatters covered the outside cabinet doors to the right of the sink. Plates and bowls to the upper left of the stove sat in a cupboard in crumbs. Tongs and scoops sat in crumbs and large food particles in a drawer to the left of the refrigerator. The B Wing Dish Machine Temps sheet directed staff to record the temperatures at the end of the cycle and stated the temperature should read 160 degrees Fahrenheit or above. If the temperature did not reach the minimum, the document directed staff to contact the manager. The log included the following temperatures which were below 160 (in degrees Fahrenheit): 8/1/24 breakfast 149 8/2/24 breakfast 138, dinner 154 8/3/24 breakfast 152, lunch 158 8/4/24 lunch 157 8/5/24 breakfast 152, dinner 155 8/6/24 lunch 153, dinner 143 8/7/24 lunch 145 8/9/24 breakfast 153, lunch 148, dinner 158 8/10/24 dinner 154 8/11/24 breakfast 153, lunch 147, dinner 153 8/12/24 dinner 158 8/13/24 lunch 151 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/14/24 at 9:51 a.m. the Dietary Manager stated there was a kink in the hose of the B Wing dishwasher that caused the machine not to reach the adequate temperature. She stated the disc should reach a minimum of 160 degrees. She stated staff should inform her if they obtained temperatures below this. She stated drawers, cabinets, and appliances should be kept clean and free of food debris and splatters. She stated staff should wipe down these surfaces. She stated they had in their books what staff should carry out with regard to cleaning but stated staff did not fulfill these duties. She stated she and Staff E would begin monitoring the completion of this. She stated staff should not enter the kitchen to wash their hands without a hair net.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 35434 Based on review of Quality Assurance and Performance Improvement(QAPI) meeting documentation, policy review, and staff interview, the facility failed to carry out Quality Assurance(QA) activities to obtain feedback, use data, and take action to conduct structured, systematic investigations and analysis of underlying causes or contributing factors of problems affecting facility-wide processes that impact quality of care, quality of life, and resident safety. The facility reported a census of 39 residents. Findings include: The Centers for Medicare and Medicaid Services(CMS) 2567, dated 2/15/24, listed, in part, the following concerns: F812 QAPI Sign-In Sheets documented the facility had QAPI meetings on the following dates: 4/19/24 and 7/26/24. The current survey, conducted 8/12/24-8/15/24 also identified the above concern. The undated facility QAPI Plan stated the facility would address key issues to continuously improve services. The plan stated the QAA committee would prioritize areas that were problem-prone. On 8/15/24 at 8:59 am., the Administrator stated with regard to QA activities, the facility hadn't done as much with dietary. She stated they needed to focus on this and focused more on nursing after the last survey.