STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Manor	737 North Highway Oakland, IA 51560

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, Electronic Health Record (EHR) review, policy review, resident interviews and staff interviews the facility failed to provide dignity and respect to 2 of 14 residents reviewed (Resident #8 and #12). The facility reported a census of 32 residents.Finding include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #8 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS also documented diagnoses of quadriplegia, generalized muscle weakness and need for assistance with personal care. An observation on 1/5/26 at 1:19 PM Staff C, Certified Nurse Assistant leave room [ROOM NUMBER]. Staff C walked down the hall to join another CNA in room [ROOM NUMBER]. An observation of Resident #8 in bed with no sheets or clothes only a brief on. Staff D, Activities Director knocked on the door on 1/5/26 at 1:28 PM and entered the room. Staff D delivered mail to Resident #8. On 1/5/26 at 1:29 PM Staff C walked down the hall from room [ROOM NUMBER] to room [ROOM NUMBER]. Staff C spoke with the resident in room [ROOM NUMBER], went down the hall, returned up the hall with lift cloth and returned to room [ROOM NUMBER]. On 1/5/26 at 1:32 PM Resident #8 turned the call light on. Another CNA requested help in room [ROOM NUMBER] from Staff C. On 1/5/26 at 1:36 PM Staff C told the CNA from room [ROOM NUMBER] she would be right back to see what Resident #8 needed. Staff C took dirty linen down the hall. On 1/5/26 at 1:37 PM CNA entered Resident #8's room to answer the call light. On 1/5/26 at 1:37 PM Staff C answered the call light in room [ROOM NUMBER]. On 1/5/26 at 1:39 PM an observation of Resident #8 with a blanket on. On 1/5/26 at 1:19 PM Resident #8 stated staff left to go get him some linen. Resident #8 stated he felt uncomfortable without a sheet on. Resident #8 stated he did feel there was a lack of dignity provided when laying in bed without a sheet on. On 1/5/26 at 1:32 PM Resident #8 stated it usually did not take that long for staff to return to cover him and that was why he turned the call light on. On 1/5/26 at 1:39 PM Resident #8 stated Staff C had covered him up and that was what he wanted. On 1/7/26 at 3:57 PM Staff C, CNA acknowledged that she was working morning shift on 1/5/26 giving showers. Staff C stated she did forget to put sheets on Resident #8's bed that morning. Staff C stated she was told she was not supposed to have a bottom sheet on the air mattress. Staff C stated when she returned to answer Resident #8's call light he asked to have the blanket put over him. Staff C stated she explained to Resident #8 that she was sorry and she got sidetracked. On 1/7/26 at 4:46 PM the Director of Nursing (DON) stated she would expect Resident #8 would have (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been covered before the staff left the room with the blanket. The DON said Staff C should provide the most dignity that she could for Resident #8. Review of policy with implemented date of 11/9/25 titled, Promoting/Maintaining Resident Dignity documented it was the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintained or enhanced the resident's quality of life by recognizing each resident's individuality. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences. All staff will maintain the resident's privacy. 2. Review of Resident #12's MDS dated [DATE] documented an admission to the facility on 6/30/25 and a Brief Interview for Mental Status (BIMS) score of 08 indicating moderate cognitive impairment. The MDS documented the following diagnoses: hemiplegia, diabetes, and depression. The MDS revealed Resident #12 depended on staff for total assistance with personal hygiene, upper and lower body dressing, and bathing. During an interview with Resident #12 on 1/7/26 at 4:15 pm she stated Staff P, CNA recently slapped her upper leg while putting her feet up in bed. She stated she was attempting to get out of bed and Staff P noticed her while walking by her room, she then entered her room, was very mean verbally and yelled at her, lifted her feet up and put them back in bed and at that time she tapped her upper leg. Resident #12 stated she told Staff P to get out of her room. During an interview with Staff P, CNA on 1/7/26 at 4:50 pm who worked at the facility for over 8 years, she revealed she assisted Resident #12 back into bed on 12/5/25 when she noticed that she was attempting to get out of bed. She was afraid that Resident #12 would fall since she couldn't walk on her own and all she could think about was safety. Resident #12 told her to leave the room and became visibly upset and said she hit her leg. Staff P stated she did not touch resident's upper leg during this action but Staff P went and reported it to the charge nurse immediately that she needed help with Resident #12. Shortly after the report, she was notified by the DON to leave the facility while they investigate the situation. During an interview with the DON on 1/8/26 at 12:21 pm she stated her expectation was for Staff P to ask for consent prior to touching a resident, verbalize actions during any cares such as pushing them in a wheelchair, pericare, show dignity, make them feel safe and respected. A review of the facility provided policy titled Abuse Prevention revised on 10/21/22 documented:The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, and staff from other agencies providing services to our residents, family members. Legal guardians, surrogates, sponsors, friends, visitors, or any other individual. Mistreatment: inappropriate treatment or exploitation of a resident. Protection: Any allegation of abuses, or neglect, misappropriation or exploitation against any employee must result in his/her immediate suspension to protect the resident.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, observation, resident interviews, and staff interviews the facility failed to provide adequate response from nursing staff to assure residents safety by not responding to call lights in a timely manner for 2 of 12 residents reviewed (Resident #6 and #16). The facility reported a census of 32 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #16 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS also documented Resident #16 was always incontinent of urine and bowels. On 1/5/26 at 3:05 PM Resident #16 stated it frequently takes longer than 15 minutes to answer the call light. Resident #16 stated staff not answering call lights within 15 minutes happened frequently on both shifts equally. 2. During continuous observation on 1/5/26 at 12:46 PM until 1:02 PM (16 minutes) a call light was observed to be unanswered in the East hallway. Review of Resident #6's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. The MDS further revealed diagnoses of renal insufficiency, neurogenic bladder (a condition where nerve damage from issues in the brain, spinal cord, or peripheral nerves disrupts normal bladder control, causing problems like incontinence, retention, or incomplete emptying due to the bladder and sphincter muscles not working together properly), and paraplegia (paralysis affecting the lower half of the body). Interview on 1/5/26 at 2:04 PM with Resident #6 revealed he had been waiting to lay down, and had his call light on. Resident #6 further revealed that it had been around 20 minutes at this time, and he was watching his watch. Resident #6 then revealed that this happens from time to time. Interview 1/7/26 at 8:21 AM with the Director of Nursing (DON) revealed her expectation is for call lights to be answered within a timely manner of 15 minutes or less. 3. During a resident council meeting held 1/8/26 at 10:46 AM with residents #12, #13, #16, #28, and #37 revealed call lights can take longer than 15 minutes at most shift changes. Review of a facility provided policy titled, Call Lights: Accessibility and Timely Response with an implementation date of 11/9/25 revealed: a. All staff members who see or hear an activated call light are responsible for responding.