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	04/22/2026

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

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, facility investigative file review, resident and staff interviews and facility policy review the facility failed to ensure 5 of 5 residents (Resident #1, #2, #3, #4, and #5) were free from misappropriation of their medication. The facility reported a census of 33 residents. Findings include: 1. According to Resident #1's quarterly Minimum Data Set (MDS) assessment tool with a reference date of 2/3/2026, she had a Brief Interview of Mental Status (BIMS) score of 8. A BIMS score of 8 suggested mild cognitive impairment. The MDS documented Resident #1 received a scheduled pain medication regimen, received an as needed (PRN) pain medications or was offered and declined. Resident #1 reported no pain during the MDS assessment. The MDS listed the following diagnoses: Parkinson's disease, renal failure, stroke, depression, atrial fibrillation, fusion of cervical and lumbar spine.A Care Plan Focus Area with a revision date of 12/4/2025 documented Resident #1 had chronic pain and increased risk for injury from decreased function related to a diagnosis of spinal fusion and spondylosis. The Focus Area documented she had routine pain management. The care plan directed staff to administer scheduled and PRN pain medications as ordered, evaluate the effectiveness of pain interventions/medications.Review of October 2025 Medication Administration Record (MAR) revealed the following order: oxycodone (scheduled II narcotic for severe pain) tablet, 5 milligrams (mg) by mouth every six hours as needed (PRN) related to left femur fracture. This order had a start date of 7/3/2024 and discontinued date of 10/24/2025.A Progress Note dated 3/4/2026 at 7:59 PM documented facility wide pain assessment, range of motion (ROM), and activities of daily living (ADLs) check in. When asked, resident denied all pain/discomfort at this time. Stated I feel good right now. She appeared to be ready to take a nap. She was alert and oriented x 2 (baseline). Resident continues to be within normal limits (WNL) for ROM and activities of daily living. Resident voiced no concerns at this time.On 4/20/2026 9:30 AM resident lying in bed. Denied having uncontrolled pain in the last month or two. Felt her pain has been managed, have discontinued some of her medications without further pain.On 4/22/2026 at 9:08 AM completed a check of narcotic count sheet and medication card. Resident #1 did not have a count sheet or medication card for oxycodone in the medication cart.2. According to Resident #2's quarterly MDS assessment tool with a reference date of 3/3/2026, he had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented he received an opioid during the review period. The MDS listed the following diagnoses: Chronic Obstructive Pulmonary Disease (COPD), heart failure, renal failure, non-Alzheimer's disease, depression, low back pain, and chronic pain.The Care Plan Focus Area with a revision date of 1/14/2026 documented Resident #2 had chronic pain and was on a scheduled pain regimen. The Care Plan directed staff to administer scheduled/PRN pain medications as ordered and to monitor for effectiveness and side effects.Review of a document titled Order Summary Report, dated 3/11/2026 documented Resident #2 had an order for oxycodone tablet, 5 mg by mouth every 24 hours PRN for breakthrough pain. The order had a start date of 1/22/2026.A Progress Note dated 3/4/2026 at 7:59 PM documented facility wide pain assessment, ROM and ADLs check in. Resident stated, my pain feels normal, it's there. No increase in it and my pain medications help. My pain is chronic and all over my body. Resident rated current pain 7 out of 10. Residents ROM at baseline, (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transfers/ADLs completed as care planned. No decline or uncontrollable pain observed/reported. Resident stated he was currently comfortable in bed and was ready to take a nap, he voiced no concerns.On 4/22/2026 at 9:11 AM resident lying in bed watching TV. Stated he felt his pain was well controlled, he has medications he can ask for if he needs it but tries to tolerate it without taking anything too invasive.On 4/22/2026 at 9:57 AM with facility staff present, observed Resident #2 had two medication cards of his oxycodone 5mg tablet, present in the medication cart. The medication cards did not appear to have been tampered with.3. According to a Significant Change MDS assessment tool with a reference date of 2/10/2026, Resident #3 had a BIMS score of 11. A BIMS score of 11 suggested mild cognitive impairment. The MDS documented he received an opioid during the review period and was on hospice. The MDS documented Resident #3 did not receive scheduled pain medications, but did receive a PRN pain medication or was offered and declined. The following diagnoses were listed for Resident #3: emphysema, atrial fibrillation, heart failure, renal failure, neurogenic bladder, non-Alzheimer's dementia, schizophrenia, post-traumatic stress disorder, palliative care, adult thrive to thrive, and spondylosis.The Care Plan Focus Area with revision date of 2/12/2026 documented Resident #3 had chronic pain. The Care Plan directed staff to administer scheduled and PRN pain medications as ordered. Staff were to evaluate the effectiveness of the pain medications.Review of a document titled Order Summary Report, dated 3/7/2026 documented Resident #3 had an order for oxycodone tablet, 5 mg by mouth every 4 hours PRN for pain. The order had a start date of 2/02/2026.A Progress Note dated 3/4/2026 at 7:30 PM documented facility wide pain assessment, ROM and ADLs check in. Resident denied any pain. He came out for each meal this shift. No sudden decline when transferring. However, resident is on hospice for overall decline. Resident voiced no concerns at this time.On 4/22/2026 at 9:08 AM with facility staff present, observed Resident #3 had one packet of his oxycodone 5mg tablets, present in the medication cart. The medication card did not appear to have been tampered with.On 4/22/2026 at 9:38 AM Resident #3 stated he did have increased pain at his groin a couple of months ago. When asked how much pain, he stated he knew it was there. Resident #3 stated today his pain is good, denied having any pain.4. According to the Quarterly MDS assessment tool with a reference date of 4/7/2026, Resident #4 had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented she received a scheduled pain medication, received a PRN medication or was offered and declined during the review period. The MDS indicated she received an opioid during the review period. The following diagnoses were listed for Resident #4: stroke, depression, emphysema, pressure ulcer to left heel, and pain.The Care Plan Focus Area with a revision date of 1/13/2026 documented Resident #4 had chronic pain and received scheduled pain medications. The Care Plan directed staff to administer scheduled/PRN pain medications as ordered and monitor for effectiveness.Review of a document titled Order Summary Report, dated 3/11/2026 documented Resident #4 had an order for oxycodone tablet, 5 mg by mouth every 12 hours PRN for breakthrough pain. The order had a start date of 1/08/2026. The Order Summary Report also documented he had an order for oxycodone 5mg, 1 tablet, twice a day (BID) for pain. This order had start date of 1/8/2026.A Progress Note dated 3/4/2026 at 7:14 PM documented facility wide pain assessment, ROM and ADLs check in. In regards to pain resident stated, she aways felt the same, her pain is from nerve damage. It's chronic and affects the left side of her body from a stroke. She rated her pain 7 out of 10; stating it's always that, I haven't had a huge increase in pain recently. Resident is alert/oriented x4. ADL at baseline, ROM WNL for this resident. No decline observed. Resident appears stable. Resident stated she has no concerns at this time.On 4/22/2026 at 9:15 AM Resident #4 denied having any increased pain in the last 2-3 months. She indicated her pain is under control and voiced no concerns.On 4/22/2026 at 9:30 AM with facility staff present, observed Resident #4 had three packets of her oxycodone 5mg tablets for PRN and scheduled orders, present in the medication cart. The medication cards did not appear to have been tampered with.5. According to a Quarterly MDS assessment tool with a reference date of 3/10/2026, Resident #5 had a BIMS score of 13. A BIMS score of 13 suggested no cognitive impairment. The MDS (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented he received an opioid and received a PRN pain medication or was offered and declined during this review period. The MDS listed the following diagnoses for Resident #5: paraplegia, renal failure, neurogenic bladder, anxiety, depression, bipolar, and chronic pain syndrome.The Care Plan Focus Area with a revision date of 12/18/2025 documented Resident #5 had chronic pain related to a diagnoses of chronic pain syndrome. The Care Plan directed staff to administer scheduled and PRN medications as ordered and to monitor for effectiveness.Review of a document titled Order Summary Report, dated 3/11/2026 documented Resident #5 had an order for oxycodone tablet, 10 mg by mouth every six hours PRN for severe pain. The order had a start date of 8/26/2024.A Progress Note dated 3/4/2026 at 7:51 PM documented facility wide pain assessment, ROM and ADLs check in. Resident denied pain at this time, rating it 0 out of 10. He stated it's better controlled now, a couple weeks ago his shoulder hurt but it felt better now. Resident had no issues performing cares on himself, transferring in and out of bed or self-propelling wheelchair in the facility. His ROM was WNL and his ADLs were at baseline. No recent decline noted. Resident denied concerns at this time.On 4/22/2026 at 9:08 AM with facility staff present, observed Resident #5 had 2 packets of his oxycodone 10mg tablets, present in the medication cart. The medication cards did not appear to have been tampered with. The pill present was pink in color and scored down the center.On 4/22/2026 at 1:00 PM Resident #5 denied having concerns about how his pain is being managed.The facility provided a document titled 5-Day Investigation Summary:Timeline-Incident was reported to the Director of Nursing (DON) by Staff A Registered Nurse (RN) on 3/4/2026 at 6:21 AM. The Administrator was contacted on 3/4/2026 at 6:27 AM.On March 4, 2026 at 6:21 AM Staff A contacted the DON to report a suspected narcotic discrepancy identified during the shift change narcotic count. Staff A stated Staff B Agency RN questioned the appearance of Resident #1's oxycodone 5mg medications while completing the controlled substance count on the [NAME] (300) medication cart with the night nurse.During the count, Staff B observed that the #59 tablet with the blister card appeared to be secured with regular medical tape, which prompted further examination. Upon closer inspection of the medication card, both nurses noted that the back of blister pack appeared to have been tampered with. The tablet located in position in #59 appeared consistent with oxycodone 5mg, however the remaining tablets in the card displayed different physical characteristics and appearance than the expected medication.Further examination revealed that each blister cavity on the back of the card had been covered with a small piece of paper tape. Upon removal and inspection, it appeared that all tablets except #59 had been replaced with a different medication. Staff A immediately took photographs of the front and back of the medication card, ensuring that no resident identifying information included. At the same time, the nurses reviewed available drug identification resources and determined that the tablets in the remaining cavities appeared consistent with loratadine (antihistamine).Following this discovery, the nursing staff initiated a review and recount of all narcotic cards located on the medication cart to determine whether additional discrepancies were present. During this review, staff identified additional oxycodone 5mg and 10mg medication cards that appeared to have been tampered with in a similar manner, with the prescribed medication replaced by what appeared to be loratadine tablets.At the time five oxycodone 5mg medication cards were identified as potentially tampered with. All affected medication cards and corresponding narcotic documentation were immediately removed from the medication cart and secured by nursing leadership pending further investigation. The DON was notified and an internal investigation was initiated.The DON contacted Staff C previous Administrator to report this medication diversion.At 7:30 AM the DON and Staff C arrived at the facility. The DON went to each cart and reexamined/counted cards with Staff A on the East (100) medication cart and Staff B on the [NAME] (300) medication cart. Upon counting with Staff A it was found that Resident #5's oxycodone 10 mg card with tablets that are pink in color was found to be tampered with as well, there appeared to be no oxycodone 10mg present in the card at this time. This medication was replaced with over the counter (OTC) pink Vitamin B-12 round tablets and the card was tampered with exactly like the others; with paper tape precisely (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	placed over each [NAME] in the pack. The DON removed the card and narcotic sheet-gathered the others and went to fully examine all of them with Staff C.Following verification of the narcotic discrepancies by the DON, Staff C and the DON initiated a detailed investigation to determine the timeframe of the diversion and identify staff members who had access to the medication carts during the relevant period.As part of the investigation, nursing leadership reviewed staff schedules, pharmacy delivery records, MAR, narcotic control sheets, and the physical narcotic blister cards associated with the affected residents. This review was conducted to establish a timeline and determine when the controlled substances may have been removed.Record review indicated that Staff D RN began working independently on the [NAME] (300) medication cart on 2/16/2026, after completing three days of orientation with facility nursing staff. Based on pharmacy delivery records and comparison with the MAR, narcotic control sheets, and the condition of the blister cards, findings suggest that the narcotic diversion may have begun shortly after the nurse began working independently on that medication cart.Physical examination of the affected blistered cards revealed that the narcotic tablets had been removed and replaced with an OTC medication, later identified as loratadine. The blister cavities appeared to have been resealed with paper tape placed on the back of the card, making the blister packs appear intact during routine counts.For example, Resident #5's oxycodone 10mg prescription was delivered to the facility during the night shift on 2/16/2026. Documentation shows that Staff D was assigned to the [NAME] (300) medication cart (where Resident #5's medications were located) independently on 2/17/2026. Upon review of the physical blister card for this medication, tape was observed covering each cavity on the back of the card, consistent with the tampering identified in other affected medication cards. Based on these findings, the timeframe for the suspected diversion is believed to have begun on or around 2/17/2026.Additional residents assigned to the [NAME] (300) medication cart whose medications were identified as tampered with include Resident #1 and Resident #3, both of whom had oxycodone 5mg tablets replaced with loratadine within their medication blister packs.On 3/2/2026 due to a temporary reduction in facility census, Staff C and the DON adjusted nursing staffing assignment, resulting in one nurse covering both medication carts after 10:00 AM. On that date Staff D began her shift at 6:00 AM on the [NAME] (300) medication cart, while Staff A began the morning medication pass on the East (100) medication cart from 6:00 AM until approximately 10:00 AM. At approximately 10:00 AM both nurses completed and verified narcotic counts on both medication carts. Following this count, Staff D was assigned responsibility for both medication carts and was provided both sets of medication cart keys from approximately 10:00 AM until 6:00 PM.Review of narcotic blister cards for Resident #2 and Resident #4 revealed similar signs of tampering, including paper tape applied to the back of the blister cavities, with the prescribed oxycodone tablets replaced with loratadine. Both residents receive scheduled oxycodone multiple times per day, and the physical condition of the blister cards suggests that the medication replacement may have occurred during this timeframe.The following information was documented in a medication diversion matrix:Resident #1 had 1 medication card of oxycodone 5mg, with 59 missing/replaced with another drug;Resident #2 had 2 medication cards of oxycodone 5mg, with 70 missing/replaced with another drug;Resident #3 had 1 medication card of oxycodone 5mg, with 11 missing/replaced with another drug;Resident #4 had 1 medication card of oxycodone 5mg, with 55 missing/replaced with another drug;Resident #5 had 2 medication cards of oxycodone 10mg, with 84 missing/replaced with another drug;A total of 7 cards affected and a total of 279 narcotic tablets missing.Investigation Conclusion:Following the facility's review of pharmacy delivery records, MARS, narcotic control sheets, staffing schedules, and the physical condition of the affected narcotic blister cards, the investigation identified Staff D as the staff member with consistent access to the medication carts during the timeframe in which the narcotic discrepancies occurred. Based on the timeline of pharmacy deliveries and staff assignments, Staff D was determined to have had access to the affected narcotic supplies during the period when the medications were believed to have been removed.The facility worked in coordination with the county (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sheriff's department during the course of the investigation. On 3/6/2026 at approximately 2:59 PM, law enforcement personnel met with facility leadership in person and reported that Staff D admitted to removing oxycodone medications from the facility and from the affected residents' narcotic supplies.The facility provided the following staff statements:Staff A documented she arrived to the facility to start her shift on 3/4/2026 at 6:00 AM. She received report on the 100/200 cart on residents. It was reported that Resident #2 was complaining more about unmanaged pain, this nurse took note. Narcotics were counted at this time. The numbers in the narcotic book matched the number of pills in each card and each card was accounted for. The overnight nurse then gave report to Staff B on the 200/300 cart. As they counted narcotics, Staff A went to the kitchen to fill her water pitcher and heard Staff B calling her name. She came out of the kitchen and Staff B told her a pill was taped back in to the card and is different from the rest of the pills in the card. Staff A took a photo of the front and back of the card to notify the DON. Upon further investigation of the medication, the pill taped back into the card was an oxycodone and the rest of the pill were loratadine based off the number and letter combo on the pill. It was then noticed by a nurse that the back of the card had a small piece of white paper tape on each pill pouch. The DON was called and notified at 6:21 AM that oxycodone 5mg tablets were missing. The DON directed Staff A to recheck all narcotic cards on both carts. Upon rechecking the backs of all narcotic cards, it was noticed that all cards with full pills of oxycodone were replaced with loratadine and taped in. The DON was notified of this as well at 6:32 AM. All of these cards were removed from cards with count sheets and taken to the DON office. Count reverified with DON at 8:15 AM. Staff A additionally documented it had been noticed over the last couple of days that Staff D had not been seen for roughly 20 minutes but then would come out of the medication room. She did not inquire what she was doing. Staff A also indicated she would go to the nurse's station commonly and Staff D would not be there. Staff A signed and dated her statement on 3/4/2026 at 10:00 AM and 12:50 PM.Staff B documented on the morning of 3/4/2026 as she was counting narcotics during shift change per norm, she notified a pill had been taped back into a slot. She then analyzed it to make sure it was the same one as all the other ones in the card but discovered it was different. She then showed it to the overnight nurse who she was counting with. She then called Staff A over to verify. Staff A took a picture of the card then proceeded to look up the pill that had been taped back into the slot. It was oxycodone 5mg at which was confusing. They then proceeded to look up the other pills on the card which came up as loratadine 10mg. The overnight nurse then pointed out that the card looked as though it had been taped up. When the card was turned around, to our surprise, every slot had been meticulously opened and taped back together. Staff A then proceeded to call the DON to make her aware of the situation at which point Staff B started to check all the narcotic cards and noticed another card with the same pattern of behavior. Staff B gave the cards to Staff A as she was on the phone with the DON. Once off the phone, Staff A then proceeded to check her medication cart and also found some cards with the same pattern. All cards had pictures taken by Staff A and were pulled from the medication carts. When the DON arrived to the facility, they proceeded to count check the carts and two more cards were found that had been tampered with. The DON proceeded to remove the cards from the cart along with their count sheets. Staff B signed her statement.The County Sheriff's Office provided a case report that included the investigator's narrative: on 3/4/2026 at about 3:00 PM we arrived at Staff D's apartment and made contact with her at the front door. The Sergeant told her that he had taken a theft report at the facility regarding the pills that had been taken off of the pill cart. He told her a large amount of oxycodone pills were taken recently and since she just got off two long shifts at the nursing home we wanted to speak with her. We told her that she was the first person we had made contact with so far other than the reporting staff. Staff D stated that she had absolutely no idea as to what could have happened to the pills. She was asked if she could think of anyone that would do this and she stated not anyone that works for the facility but perhaps one of the temporary agency employees could have done it. Staff D said that she did just work the last two shift of 6:00 AM to 10:00 PM and didn't notice (continued on next page)

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Essentially this would keep anyone from looking at the back of the packages or really inspecting the packages. She claimed that there are probably around 10 people that would have access to the key for the medication cart while they are working. She stated that only one person at a time would have the key though. We were unable to locate Staff D at her apartment until 3/6/2026. Before we could get together to talk with her the Sergeant saw Staff D driving was able to make a traffic stop. The investigator arrived on location and met with the Sergeant. He was talking with Staff D in front of his cruiser and told me that his stop was done and she was just waiting for a ride to come pick her up. I walked up to Staff D and told her that she was free to go and I would like to speak with her a little bit more about the pill thing. If she didn't want to talk to me she didn't have to if she didn't want to. I asked if she wanted to speak with me in her car or mine or stand outside; asked her how she wanted to do it. She said I don't care so I asked if she wanted to sit in my car. She said she did have a ride coming and walked with me back to my car where she sat in the front seat. I told Staff D that when we came to her house the other day we talked to her early on and didn't really know much about this incident yet. I told her that that information was new and since then it's been pretty clear that she was with the pills alone. Other people at the nursing home have given statements, time lines and what people have seen, and everything kept coming back to her as the one responsible for taking the pills. I told her that it wasn't really a matter of whether she took the pills as it was clear that she did take them as this behavior has been happening for a couple years. I told her that I was assuming she was consuming the pills and had a bit of an addiction to them. Staff D then said I did. I told her I think this is being carried on or she is selling them which either way is not great but I was more concerned she has a serious issue and that is why these pills keep coming up missing. I told her that we already know she did this and wanted to know where the pills are and what her thought process was during this. Staff D then said they are disposed of; she said her family already did that. I asked her when the pills were taken and if it was over the course of several days or all at once. Staff D said that it was over the course of a period of time. I told her that they were recently noticed and asked if pills were taken before this or recently. She said that the pills were swapped out prior to that. I asked Staff D if she brought the replacement pills with her or if they were already there. She said that they were already on site. I asked her if she knew how many pills were taken out of the blister packets and she stated a hundred or more. I asked if she still had them and she said that she flushed them all down the toilet. I asked her if she has ever done this before and she nodded her head no. She said she broke her foot recently and was in a lot of pain. She said her prescriptions were the same as what pills were taken from the nursing home; oxycodone. Staff D stated that she brought home the pills over the course of like two months but never sold any of them. I asked her how the packets were opened. She said that the blister was punctured, and I asked her if it was sliced with a knife and she said yeah. I then asked if she put little pieces of tape over them and she nodded yes.On 4/21/2026 at 11:10 AM the responding Sergeant with the County Sheriff's office stated once he got the call about diversion, he went to the facility and got the gest of what had taken place. The DON showed him the medication cards, sign out sheets, and a possible suspect but did not have supporting evidence. He reached out to the investigator and spoke to him a bit and went to Staff D's apartment to see what they could get from her. During their initial interview they did not get anything out of her but they also did not have (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	evidence to suspect her. Fast forward a couple days, they did a follow up with the DON. She had received statements from nursing staff that gave them a little bit more leverage against Staff D. The Sergeant later performed a traffic stop with Staff D. Once the Sergeant completed his traffic stop, the Investigator then questioned Staff D. He stated long story short, he asked her about taking the pills and if she was addicted to them or selling them. Staff D told him she was addicted to them and started tampering with the packets and taking the medications a couple of months ago. She admitted to having an addiction problem because of an ankle injury.On 4/21/2026 at 12:49 PM Staff B stated she trained Staff D when she started at the facility and did not notice anything odd during that time. On the day she noticed the discrepancies, she was doing her narcotic counts with the over night nurse and noticed the back of the medication packet was opened a little bit. She could see it through the front of the card. She looked at the entire card to make sure all were the same but the numbers were different from the pill that was located in the opened blister. She called Staff A over to have her verify with her. Staff A noticed the pill was different from the others too. The other pills in the medication card were loratadine. When they turned the card over, each blister had been taped on the far-right side. Once they noticed this, they went through the entire medication cart and the second medication cart. They noticed other medication cards were the same way. She could not recall how many medication cards were tampered with. The other medication cards they found to be tampered with were also replaced with medications that looked similar to the prescribed medication. The DON was notified of their initial findings and again they learned there were more medications cards that had been tampered with. They pulled all of those cards out of the medication carts so Staff A could take pictures of them. Staff B believed Staff D had worked the day prior to discovering this issue. On 4/22/2026 at 9:08 AM Staff B obtained a bottle of Vitamin B-12 1000 micrograms (mcg) and removed a pill from the bottle. The pill was circular shaped, a lighter color of pink than Resident #5's oxycodone pills that were present in his medication card. The Vitamin B-12 pill did not have a score down the middle.On 4/22/2026 at 10:48 Staff A stated she was on the 100 hall cart and Staff B was on the 300 hall cart. While Staff B received report from the overnight nurse, Staff B called her name. She reported that the pills were different in Resident #5's oxycodone pill packet. The pill was taped in the packet and looked different from the other pills. They got online and looked up the numbers that were on the pills; it was oxycodone and that's what the medication card label read as well. But they noticed the other pills looked different from this one. They turned the card over and noticed the back had white paper tape on each individual blister. They turned the card back over and looked up the numbers on the other pills and found they all were Vitamin B-12. They found another medication card that had tape on the back of it on each individual blister. Those oxycodone pills had been replaced with loratadine. Staff A removed the cards and went to the medication room and called the DON. She let her know all of Resident #5's oxycodone from his medication cards were gone. The DON asked her to go to the other cart to inspect those medications cards as well. When they did this, they noticed every medication card that was to have oxycodone in it, did not have oxycodone in them. The pills had been replaced with loratadine. It looked like the person took their fingernail to the curve at the back of the blister and removed the medication. She called the DON again to let her know what they found. She told Staff A to lock up all the medication cards with narcotic sheets until she arrives at the facility. Staff A stated Staff D always wanted to be on the 300 cart never on the 100 cart. The 300 cart had more narcotics on it.On 4/22/2026 at 1:04 PM the DON stated on 3/4/2026 around 5:45-5:50 AM she received a call from Staff A and found a huge narcotic discrepancy. During narcotic count Staff B noticed Resident #1's oxycodone had one of the blisters taped shut and the pill looked different than the others. They looked up the pill number and it was loratadine same as the other pills in the medication cards. Staff A took pictures of the cards front and back and sent them to her. The DON called Staff A and told her to redo their narcotic count and look for other discrepancies. When they went to the other medication cart they pulled those cards and called her back to tell her that the oxycodone had been taken from the medicati

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	165230	A. Building B. Wing	04/22/2026

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on clinical record review, facility investigative file review, staff interviews and facility policy review the facility failed to report an allegation of abuse to the State Agency no later than 2 hours after the allegation of abuse was suspected. The facility reported a census of 33 residents.Findings include: 1. According to Resident #1's quarterly Minimum Data Set (MDS) assessment tool with a reference date of 2/3/2026, she had a Brief Interview of Mental Status (BIMS) score of 8. A BIMS score of 8 suggested mild cognitive impairment. The MDS documented Resident #1 received a scheduled pain medication regimen, received an as needed (PRN) pain medications or was offered and declined. Resident #1 reported no pain during the MDS assessment. The MDS listed the following diagnoses: Parkinson's disease, renal failure, stroke, depression, atrial fibrillation, fusion of cervical and lumbar spine. A Care Plan Focus Area with a revision date of 12/4/2025 documented Resident #1 had chronic pain and increased risk for injury from decreased function related to a diagnosis of spinal fusion and spondylosis. The Focus Area documented she was had routine pain management. The care plan directed staff to administer scheduled and PRN pain medications as ordered, evaluate the effectiveness of pain interventions/medications.Review of October 2025 Medication Administration Record (MAR) revealed the following order: oxycodone (scheduled II narcotic for severe pain) tablet, 5 milligrams (mg) by mouth every six hours as needed (PRN) related to left femur fracture. This order had a start date of 7/3/2024 and discontinued date of 10/24/2025.On 4/20/2026 9:30 AM resident lying in bed. Denied having uncontrolled pain in the last month or two. Felt her pain has been managed, have discontinued some of her medications without further pain.On 4/22/2026 at 9:08 AM completed a check of narcotic count sheet and medication card. Resident #1 did not have a count sheet or medication card for oxycodone in the medication cart.2. According to Resident #2's quarterly MDS assessment tool with a reference date of 3/3/2026, he had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented he received an opioid during the review period. The MDS listed the following diagnoses: Chronic Obstructive Pulmonary Disease (COPD), heart failure, renal failure, non-Alzheimer's disease, depression, low back pain, and chronic pain. The Care Plan Focus Area with a revision date of 1/14/2026 documented Resident #2 had chronic pain and was on a scheduled pain regimen. The Care Plan directed staff to administer scheduled/PRN pain medications as ordered and to monitor for effectiveness and side effects. Review of a document titled Order Summary Report, dated 3/11/2026 documented Resident #2 had an order for oxycodone tablet, 5 mg by mouth every 24 hours PRN for breakthrough pain. The order had a start date of 1/22/2026.On 4/22/2026 at 9:11 AM resident lying in bed watching TV. Stated he felt his pain was well controlled, he has medications he can ask for if he needs it but tries to tolerate it without taking anything too invasive.On 4/22/2026 at 9:57 AM with facility staff present, observed Resident #2 had two medication cards of his oxycodone 5mg tablet, present in the medication cart. The medication cards did not appear to have been tampered with.3. According to a Significant Change MDS assessment tool with a reference date of 2/10/2026, Resident #3 had a BIMS score of 11. A BIMS score of 11 suggested mild cognitive impairment. The MDS documented he received an opioid during the review period and was on hospice. The MDS documented Resident #3 did not receive scheduled pain medications, but did receive a PRN pain medication or was offered and declined. The following diagnoses were listed for Resident #3: emphysema, atrial fibrillation, heart failure, renal failure, neurogenic bladder, non-Alzheimer's dementia, schizophrenia, post-traumatic stress disorder, palliative care, adult thrive to thrive, and spondylosis. The Care Plan Focus Area with revision date of 2/12/2026 documented Resident #3 had chronic pain. The Care Plan directed staff to administer scheduled and PRN pain medications as ordered. Staff were to evaluate the effectiveness of the pain medications.Review of a document titled Order Summary Report, dated 3/7/2026 documented Resident #3 had an order for oxycodone tablet, 5 mg by mouth every 4 hours PRN for pain. The order (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had a start date of 2/02/2026.On 4/22/2026 at 9:08 AM with facility staff present, observed Resident #3 had one packet of his oxycodone 5mg tablets, present in the medication cart. The medication card did not appear to have been tampered with.On 4/22/2026 at 9:38 AM Resident #3 stated he did have increased pain at his groin a couple of months ago. When asked how much pain, he stated he knew it was there. Resident #3 stated today his pain is good, denied having any pain.4. According to the Quarterly MDS assessment tool with a reference date of 4/7/2026, Resident #4 had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented she received a scheduled pain medication, received a PRN medication or was offered and declined during the review period. The MDS indicated she received an opioid during the review period. The following diagnoses were listed for Resident #4: stroke, depression, emphysema, pressure ulcer to left heel, and pain.The Care Plan Focus Area with a revision date of 1/13/2026 documented Resident #4 had chronic pain and received scheduled pain medications. The Care Plan directed staff to administer scheduled/PRN pain medications as ordered and monitor for effectiveness.Review of a document titled Order Summary Report, dated 3/11/2026 documented Resident #4 had an order for oxycodone tablet, 5 mg by mouth every 12 hours PRN for breakthrough pain. The order had a start date of 1/08/2026. The Order Summary Report also documented he had an order for oxycodone 5mg, 1 tablet, twice a day (BID) for pain. This order had start date of 1/8/2026.On 4/22/2026 at 9:15 AM Resident #4 denied having any increased pain in the last 2-3 months. She indicated her pain is under control and voiced no concerns.On 4/22/2026 at 9:30 AM with facility staff present, observed Resident #4 had three packets of her oxycodone 5mg tablets for PRN and scheduled orders, present in the medication cart. The medication cards did not appear to have been tampered with.5. According to a Quarterly MDS assessment tool with a reference date of 3/10/2026, Resident #5 had a BIMS score of 13. A BIMS score of 13 suggested no cognitive impairment. The MDS documented he received an opioid and received a PRN pain medication or was offered and declined during this review period. The MDS listed the following diagnoses for Resident #5: paraplegia, renal failure, neurogenic bladder, anxiety, depression, bipolar, and chronic pain syndrome.The Care Plan Focus Area with a revision date of 12/18/2025 documented Resident #5 had chronic pain related to a diagnoses of chronic pain syndrome. The Care Plan directed staff to administer scheduled and PRN medications as ordered and to monitor for effectiveness.Review of a document titled Order Summary Report, dated 3/11/2026 documented Resident #5 had an order for oxycodone tablet, 10 mg by mouth every six hours PRN for severe pain. The order had a start date of 8/26/2024.On 4/22/2026 at 9:08 AM with facility staff present, observed Resident #5 had 2 packets of his oxycodone 10mg tablets, present in the medication cart. The medication cards did not appear to have been tampered with. The pill present was pink in color and scored down the center.On 4/22/2026 at 1:00 PM Resident #5 denied having concerns about how his pain is being managed.The facility provided a document titled 5-Day Investigation Summary:Timeline-Incident was reported to the Director of Nursing (DON) by Staff A Registered Nurse (RN) on 3/4/2026 at 6:21 AM. The Administrator was contacted on 3/4/2026 at 6:27 AM.On March 4, 2026 at 6:21 AM Staff A contacted the DON to report a suspected narcotic discrepancy identified during the shift change narcotic count. Staff A stated Staff B Agency RN questioned the appearance of Resident #1's oxycodone 5mg medications while completing the controlled substance count on the [NAME] (300) medication cart with the night nurse.During the count, Staff B observed that the #59 tablet with the blister card appeared to be secured with regular medical tape, which prompted further examination. Upon closer inspection of the medication card, both nurses noted that the back of blister pack appeared to have been tampered with. The tablet located in position in #59 appeared consistent with oxycodone 5mg, however the remaining tablets in the card displayed different physical characteristics and appearance than the expected medication.Further examination revealed that each blister cavity on the back of the card had been covered with a small piece of paper tape. Upon removal and inspection, it appeared that all tablets except #59 had been replaced with a different medication. Staff A immediately took photographs of (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the front and back of the medication card, ensuring that no resident identifying information included. At the same time, the nurses reviewed available drug identification resources and determined that the tablets in the remaining cavities appeared consistent with loratadine (antihistamine).Following this discovery, the nursing staff initiated a review and recount of all narcotic cards located on the medication cart to determine whether additional discrepancies were present. During this review, staff identified additional oxycodone 5mg and 10mg medication cards that appeared to have been tampered with in a similar manner, with the prescribed medication replace by what appeared to be loratadine tablets.At the time five oxycodone 5mg medication cards were identified as potentially tampered with. All affected medication cards and corresponding narcotic documentation were immediately removed from the medication cart and secured by nursing leadership pending further investigation. The DON was notified and an internal investigation was initiated.The DON contacted Staff C previous Administrator at 6:27 AM to report this medication diversion.At 7:30 AM the DON and Staff C arrived at the facility. The DON went to each cart and reexamined/counted cards with Staff A on the East (100) medication cart and Staff B on the [NAME] (300) medication cart. Upon counting with Staff A it was found that Resident #5's oxycodone 10 mg card with tablets that are pink in color was found to be tampered with as well, there appeared to be no oxycodone 10mg present in the card at this time. This medication was replaced with over the counter (OTC) pink Vitamin B-12 round tablets and the card was tampered with exactly like the others; with paper tape precisely placed over each bubble in the pack. The DON removed the card and narcotic sheet-gathered the others and went to fully examine all of them with Staff C.Additional residents assigned to the [NAME] (300) medication cart whose medications were identified as tampered with include Resident #1 and Resident #3, both of whom had oxycodone 5mg tablets replaced with loratadine within their medication blister packs.Review of narcotic blister cards for Resident #2 and Resident #4 revealed similar signs of tampering, including paper tape applied to the back of the blister cavities, with the prescribed oxycodone tablets replaced with loratadine. Both residents receive scheduled oxycodone multiple times per day, and the physical condition of the blister cards suggests that the medication replacement may have occurred during this timeframe.The following information was documented in a medication diversion matrix:a) Resident #1 had 1 medication card of oxycodone 5mg, with 59 missing/replaced with another drug;b) Resident #2 had 2 medication cards of oxycodone 5mg, with 70 missing/replaced with another drug;c) Resident #3 had 1 medication card of oxycodone 5mg, with 11 missing/replaced with another drug;d) Resident #4 had 1 medication card of oxycodone 5mg, with 55 missing/replaced with another drug;e) Resident #5 had 2 medication cards of oxycodone 10mg, with 84 missing/replaced with another drug;f) A total of 7 cards affected and a total of 279 narcotic tablets missing. On 4/22/2026 at 2:10 PM a State Agency Complaint Intake Specialist provided a print screen of the intake the facility reported. The print screen documented the reporting party was Staff C and was aware of the allegation of missing medication occurred on 3/4/2026 at 6:10 AM. The print screen documented a submission date of 3/5/2026 at 11:21 AM. On 4/22/2026 at 2:10 PM Staff C stated he was made aware of the incident by the DON and filed the report with the State Agency. He stated he reported it on 3/4/2026 but not top notch in the technology world and did not get the information completely submitted. He went in the next morning to make sure he submitted it and learned he hadn't saved it. It was user error on his part that it was not submitted correctly. The facility provided a policy titled Abuse, Neglect and Exploitation with an implemented date of 1/9/2025. It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. IV. Reporting/ResponseThe facility will have written procedures that include:Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, orNot later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on clinical record review, facility investigative file review, staff interviews and facility policy review the facility failed to store narcotics to minimize loss when 1 of 3 residents (Resident #1) discontinued narcotic pain medication remained in the medication cart for almost 6 months. This resulted the in pills being misappropriated by a facility staff member. The facility reported a census of 33 residents. Findings include: According to Resident #1's quarterly Minimum Data Set (MDS) assessment tool with a reference date of 2/3/2026, she had a Brief Interview of Mental Status (BIMS) score of 8. A BIMS score of 8 suggested mild cognitive impairment. The MDS documented Resident #1 received a scheduled pain medication regimen, received an as needed (PRN) pain medications or was offered and declined. Resident #1 reported no pain during the MDS assessment. The MDS listed the following diagnoses: Parkinson's disease, renal failure, stroke, depression, atrial fibrillation, fusion of cervical and lumbar spine.A Care Plan Focus Area with a revision date of 12/4/2025 documented Resident #1 had chronic pain and increased risk for injury from decreased function related to a diagnosis of spinal fusion and spondylosis. The Focus Area documented she was had routine pain management. The care plan directed staff to administer scheduled and PRN pain medications as ordered, evaluate the effectiveness of pain interventions/medications.Review of October 2025 Medication Administration Record (MAR) revealed the following order: oxycodone (scheduled II narcotic for severe pain) tablet, 5 milligrams (mg) by mouth every six hours as needed (PRN) related to left femur fracture. This order had a start date of 7/3/2024 and discontinued date of 10/24/2025.Record review revealed the a renew orders form that listed Resident #1's oxycodone 5mg tablet to be discontinued on 10/24/2025. The form documented this was completed.On 4/22/2026 at 1:04 PM the Director of Nursing (DON) was asked how Resident #1's discontinued oxycodone medication card was missed and not pulled out of the medication cart. She believed it got missed due to inconsistency in staffing. The medication should have been destroyed by two licensed nurses. If the medication card was full and not touched it could have been returned to pharmacy.The facility provided a policy titled Controlled Substance Administration & Accountability with a copyright date of 2025. It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure.Policy Explanation and Compliance Guidelines:4. Obtaining/Removing/Destroying Medications:d) Two licensed staff must witness any disposal or destruction of a controlled substance and document same on the Drug Disposition Record, Controlled Drug Record, or via the automated dispensing system.6. Returning Medications:a) Non-stock drugs are returned to the pharmacy when no longer needed for the patient in whose name they were issued as per state or pharmacy regulations. (See also Unused Medication Return Policy.)b) Controlled substances returned to the pharmacy are delivered by a licensed nurse, consultant pharmacist, or pharmacy technician.c) Unused controlled substances may be returned to stock if they are still in the original unopened tamper proof packaging. (See also Unused Medication Return Policy.)d) Two licensed staff must witness return of controlled substances.e) If the package has been opened or the tamper seal removed, it must be destroyed. (See also Destruction of Unused Drugs Policy.)Two licensed staff must witness the disposal of controlled substances.