STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165269	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearview Home	406 West Washington Mount Ayr, IA 50854

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility investigative file review, and facility policy review the facility failed to ensure 2 of 3 residents (Resident #3 and #4) were free from abuse. Staff had used their personal cell phones to take a photo of Resident #3 and a video of Resident #4 without their consent. The facility reported a census of 70 residents.Findings include:The facility corrected the deficient practice per past noncompliance on 5/22/2026 through the following actions: -all facility staff educated on the facility's Abuse Policy,-all facility staff educated on the facility's HIPPA Policy,-all facility staff educated on the facility's Social Media Policy,-the facility's Cell Phone Policy was updated,-all facility staff educated on the facility's Cell Phone Policy. 1. According to an annual Minimum Data Set (MDS) assessment tool with a reference date of 2/27/2026 documented Resident #3 had a Brief Interview of Mental Status (BIMS) score of 0. A BIMS score of 0 suggested severe cognitive impairment. The MDS documented she was dependent on staff for toileting hygiene and toilet transfers. Resident #3 was always incontinent of bowel and bladder. The MDS listed the following diagnoses for Resident #3: dementia, anemia, renal failure, arthritis, anxiety, depression, overweight, diarrhea, and metabolic encephalopathy.A Care Plan Focus Area with a revision date of 6/27/2025 documented Resident #3 required assistance with Activities of Daily Living (ADLs), utilized a mechanical lift for transfers and not independently mobile. She required the assistance of two staff for transfers and the use of a mechanical lift for all transfers.A second Care Plan Focus Area with a revision date of 7/15/2024 documented Resident #3 required the assistance of two staff to use the toilet or bedside commode. The Care Plan documented she worse an adult brief as she was always incontinent of bowel and bladder. Staff were encouraged to check and change Resident #3 and anticipate her needs.The facility investigative file including the following:-Summary of findings: the Director of Nursing (DON) received a call on 5/16/26 from a community member that she had been contacted about an inappropriate snapchat taken by Staff K Certified Nursing Assistant (CNA) on 5/16/2026 at approximately 3:45 PM. The DON immediately notified the Assistant Administrator, who had just received a phone from another community member asking where they were as she had something important to tell him. The DON and Assistant Administrator went immediately to facility and removed Staff K from the floor to begin interviewing her. Staff K did confess to taking a snap chat at approximately 2:30 PM of a soiled brief (with stool present) that was on Resident #3. Staff K stated the snapchat was of the resident's lower thighs with the soiled brief unfolded between her legs. Staff K stated it did not have peri area in the photo but she sent it to one of her friends via snap chat. This friend was not a facility staff member. Staff K denied saving the photo on her phone and acknowledged that she knew it was not appropriate. Staff K stated she had been educated on dependent adult abuse policy, social media policy, and cell phone policy. When asked if she had ever taken photos of residents in the past she said no, but said she had taken photos of soiled briefs or linens in the utility room before with no residents present. When asked if she had ever heard reports or seen this happen with other staff, she said no. Staff K's employment was terminated.-The Deputy Sheriff was notified and he was informed they needed to know the details/content of the snapchat (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and he confirmed he would interview the community member about the snap tomorrow and report back to the facility. -On 5/18/2026 the Deputy Sheriff called and discussed his interview. The community member stated they did have the picture because it was on snapchat. They stated they saw legs and a complete blowout in the brief and couldn't tell if it showed complete nudity because blowout was so bad. The community member told the Sheriff this was not the first time this has happened. The facility asked if the past pictures included residents or not and the Sheriff said he would ask and get back in touch. -On 5/20/2026 the Sheriff called the Assistant Administrator and informed him that the community member said the past snaps were only of soiled linens and briefs, no person or skin ever in the photos. -Corrective Action: Immediately separated Staff K from all residents and did terminate her effective immediately. On 5/16/2026 all staff received abuse policy, cell phone policy, and social media policy. Follow-up interviews with all nurses were conducted asking if they witnessed Staff K on her cell phone taking pictures or videos or if ever received reports of such behavior; they all denied this. The Administration and department heads reviewed and revised cell phone policy. Staff in-service was held 5/21/2026 to review updated cell phone policy and again reviewed abuse policy, social media policy, and HIPPA. On 5/27/2026 at 2:09 PM the Assistant Administrator stated he got a call from the DON stating they have a problem. She had received a call from a community member about Staff K taking photos of a resident on snapchat. He also had a community member call to report a Staff K had taken a snapchat photo of a resident's soiled brief at approximately 2:30 PM on 5/16/2026. The DON and himself went to the facility and Staff K stated the photo was of Resident #3's thighs and a soiled brief was unfolded between her legs. Staff K admitted to sending it to someone that was not a facility staff member and the photo was not saved on her phone. Staff K acknowledged it was not appropriate and the only other photos she had taken while at work were of soiled briefs and linens. The Assistant Administrator stated Resident #3 would not be capable of answering if it was ok to take the photo.On 5/29/2026 at 11:09 AM the DON stated a community member called to tell her about a video that Staff K had sent out of a resident's brief full of stool. The DON called the Assistant Administrator and he said another community member wanted to talk to him, they assumed it was of the same issue. When they both arrived at the facility, they pulled Staff K in to talk to her. She admitted to taking the photo of Resident #3's upper thighs and her soiled brief pulled down. Staff K denied any of the resident's peri-area in the photo on snapchat. Staff K could not say why she took the photo but was able to tell them the photo was of Resident #3's soiled brief. The DON stated she had heard of Staff K taking photos while in the dirty utility room of dirty briefs. The DON attempted to talk to Resident #3 about what happened but she had no idea what had taken place. They started to do education that night on the following policies: cell phone, social media, and abuse. They initiated that all cell phones are to be placed in a basket and placed in a locked medication cart at the beginning of each shift. 2. According to a significant change MDS assessment tool with a reference date of 2/28/2026 documented Resident #4 had a BIMS score of 5. A BIMS score 5 suggested severe cognitive impairment. The MDS documented he required supervision or touching assistance for toileting hygiene, was independent to go from a sitting to standing position and toilet transfers. The MDS documented he was occasionally incontinent of urine and frequently incontinent of bowel. The MDS listed the following diagnoses for Resident #4: encephalopathy, cancer, benign prostatic hyperplasia, renal failure, urinary tract infection (UTI), dementia, depression, and neutropenia.A Care Plan Focus Area with a revision date of 4/6/2026 documented Resident #4 was independent without assisted devices for transfers and ambulation.A Progress Noted documented on 4/1/2026 at 12:37 PM documented Resident #4 was discharged to another facility's memory care unit.The facility investigative file included the following:-On 5/20/2026 Staff G Certified Nursing Assistant (CNA) signed and dated the following typed statement: I was walking into the locker room at school when Staff I CNA said Hey look at this and she had put her phone in front of me. It was a video of a male resident; I don't remember his name. He was standing in the chapel with his back to the chapel door and I could hear him peeing into the trashcan as the video zoomed in on him. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff I's face was also halfway in the photo. We both laughed, then the bell rang so I left to go to class. I don't remember how long ago it happened, probably over a month ago. I did not report it because I did not feel like I saw anything inappropriate in the video because he was fully dressed. -Summary of Findings: the Director of Nursing (DON) was notified by Staff H Registered Nursing (RN) on 5/19/2026 at approximately 8:45 PM that Staff G had notified her of a video she had seen on another employee's phone. The video was of a male resident urinating in a trashcan in the chapel. The DON called Staff G on 5/19/2026 at approximately 9:30 PM to confirm. Staff G reported that she was in the locker room at school, she could not remember the date but reports it was over a month ago, when Staff I showed her the video. Staff G stated the video was of half of Staff I's face with a male resident in the background with his back to the camera. Staff G stated that she could hear him urinating but there was no context on the video. Staff G stated the man was fully clothed. The DON did check the CNA schedule and confirmed Staff I was not on the schedule for that evening, late night or the next morning. No resident assessment completed as Resident #4 had been discharged to an assisted living facility closer to facility on 4/1/2026. The DON and Social Worker entered Resident #4 on 5/20/2026 at approximately 9:00 AM. The DON asked if Staff I knew why they were interviewing her and she said yes, I think so. Staff I was asked if she ever sent a video of residents to anyone and she said, yes. Staff I acknowledged the video was of a male resident urinating in a trash can in the chapel. Staff I stated she sent the video in a snapchat group consisting of 5 other CNAs at the facility. Staff I stated she no longer had the video on her phone. The DON questioned Staff I on how she was able to show the video to someone at a later time in the school locker that was not in a snapchat group if it was not saved on her phone. Staff I stated I don't remember but the video is not on my phone anymore. Staff I was asked if there were any other residents in the video, she stated no just him. Staff I stated she was sitting in center lobby; I turned my phone camera to selfie mode and I could see Resident #4 standing inside the chapel door peeing in a trashcan with his back to her. He was completely dressed, there was no nudity in the photo at all. Staff I stated the photo was taking a while ago, like months ago. When asked if she had taken pictures or videos of any other residents on her phone, she stated yes but it was taken at a wrestling meet. Staff I showed the DON and Social Worker of a photo of herself with a previous resident sitting on the [NAME] in the high school gym, smiling for the camera. The five staff members in the snap chat group were asked if they were sent or viewed a snapchat video of a male resident urinating in a trashcan in the chapel at the facility. All five denied seeing or receiving a video. Due to Staff I claiming she sent it via snapchat and the fact that she showed Staff G at a later time, we reinterviewed Staff I in the afternoon of 5/20/2026 to ensure Staff I had gone through her phone as to whether or not she could produce the snapchat video or if it was a video in her camera roll. Staff I stated she went through her snapchat as well as her phone gallery and that the video was no longer on her phone. At this time Staff I stated that the video was only of her face, that the resident wasn't visible in the snap. She was asked why she had originally stated that morning that the resident was visible but now wasn't. Attempted to clarify as another staff member had reported Staff I had zoomed in on the trash can the resident was urinating in. Staff I denied zooming in on anything and continued to stated the resident was never visible in the video she had taken. Staff I was re-interviewed on 5/22/2026 at 11:10 AM due to having more questions, her changes regarding the incident. When asked what the video was of, she stated myself and a caption that stated Resident #4 is peeing in the trash can. She denied zooming in on the trash can and that she was sitting outside the chapel with another resident. At that time she heard someone starting to pee in the trash can. Staff I stated she could not remember exactly but did not think Resident #4 was at all visible in the video. Staff I was terminated on 5/20/2026. -The facility's cell phone policy was updated on 5/21/2026. An all-staff in-service was completed on 5/21/2026 related to recent incidents, again discussing the abuse policy, social media policy, HIPPA, and went over the updated cell phone policy. Those staff that were not present at the in-service are being visited with 1-1 by administration.On 5/28/2026 at 9:35 AM Staff E CNA stated staff are not allowed to take photos or (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	videos of residents with their cell phones. When asked what if it's a photo without the resident's face in it, she said absolutely not.On 5/28/2026 at 9:51 AM Staff H Registered Nurse (RN) stated she received a text from a staff member about an incident and she told that staff member it needed to be reported. Staff G came up to another staff member and asked if they were part of a group snapchat because apparently, they send photos and videos of residents all the time. Staff H called the DON to tell her what she was informed of regarding the group snapchat. Staff H stated she did not see any photos or videos, just that she was told they sent them in a snapchat group. When asked if staff are allowed to take photos or videos of residents, she stated absolutely not; even if there were no identifying characteristics of the resident.On 5/28/2026 at 10:25 AM Staff C CNA denied ever seeing photos or videos of residents on staff's phones. She added staff are not allowed to take photos of residents with their phones. When asked what if the resident's face was not showing, could the photo be taken she said no she would not even take a photo of an injury if the nurse asked her to.On 5/28/2026 at 10:29 AM Staff D CNA stated she has not seen any photos of residents on other staff members' phones. She stated staff are not allowed to take photos of residents with their phones even if the photos do not include the resident's face. She added they are not allowed to take photos of residents or anything to do with them.On 5/28/2026 at 10:44 AM Staff F CNA stated only activity staff are allowed to take photos of residents. When asked if floor staff can take photos of residents even if their faces are not included, she stated no. On 5/28/2026 at 10:59 AM Staff G stated she was in the high school locker room when Staff I said look at this, it's funny. On Staff I's phone was a video of a male peeing in a trash can in the chapel at the facility. The school bell rang, so she went to class. She did not recognize the male, he was fully clothed, there were no other resident present. This video was on Staff I's snapchat app and did not say if she had sent it to anyone. Staff G acknowledged she did not tell anyone about this. She stated from the time she saw the photo to the time it was reported to the facility it was probably longer than a month. She did not see any naked parts of the man and did not feel it was severe enough issue to report it. She stated after the DON interviewed her, they went over the handbook for HIPPA, cell phones are to be in the medication cart locked up and they went over the social media policy too. She added only the activity department is allowed to take any photos.On 5/28/2026 at 12:10 PM the Social Worker stated when her and the DON spoke to Staff I she acknowledged to taking the video of Resident #4 and she should not have done it. Staff I stated she knew it was stupid and should not have done it. When asked to talk about the video, Staff I stated she was on the couch outside of the chapel and another resident was sitting with her. She went to take a selfie and noticed Resident #4 was in the chapel with his back towards her, urinating in a trash can. Staff I stated it was Resident #4 and she had sent it in a group snapchat with 5 other staff members. When they interviewed those other staff members they denied seeing this video of Resident #4.On 5/28/2026 at 12:42 PM Staff B Registered Nurse (RN) stated she has not seen any photos or videos of residents on staff's phones. She indicated staff are not allowed to take photos or videos are residents with their phones even if there is nothing to identify the resident in the photo such as a hand.On 5/29/2026 at 11:23 AM the DON stated Staff H had called her at home on 5/19/2026 to let her know there is a snapchat group that had an inappropriate picture in it and just wanted her aware. The DON called the Assistant Administrator to inform him. They called Staff G and she stated she was in the school locker room when Staff I said look at this. Staff I got her phone out and showed a video of a guy in the background and Staff I's face in the frame. The guy was peeing in a trash can in the chapel. The video zoomed in on the trash can but the guy was fully dressed and had his back to the phone. When they asked Staff G why she did not report it she told them she did not see any nudity so she did not feel like it needed to be reported. The DON let her know that if she ever had a question about whether something should be reported, to report it. The DON and the Social Worker interviewed Staff I and she admitted to sending a video of a resident urinating in a trash can, to five staff members in a snapchat group. She denied having the video on her phone but they questioned how she was able to show Staff G the video if it was not on her phone. Staff I stated she did not know but it (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not on her phone anymore. Staff I stated this took place about a month ago and had no other photos or videos of residents on her phone. Staff I stated the video was in selfie mode and she could see Resident #4 peeing in the background. She stated the resident was fully clothed, no nudity at all. When they spoke to the five girls in the snapchat group, they could not recall seeing or receiving a video of that. If they did, they stated they would have reported it. When the DON called Staff I to clarify a few things, she stated it was just her face in the video, not the resident. She reported it was a selfie with a caption that said Resident #4 peeing in the can. Staff I was terminated and education to all staff was started. The DON stated staff are not to take photos or videos of residents even if there are no identifying characteristics included.The facility provided a document titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting policy. The policy documented all residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This includes prohibiting nursing facility staff from taking part in acts that result in person degradation, including the taking or using photographs or recordings in any manner that would demean or humiliate a resident, and prohibits using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and/or recordings on social media or through multimedia messages. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.The facility provided a document titled Social Media Policy. The policy documented personal use of social media is never permitted on working time. DO NOT use social media to post, upload, send, or otherwise share or disclose a photo or video of any resident without prior written permission of the resident or resident's authorized agent as required by applicable law. This prohibition includes photos and videos where the resident is not easily identifiable (a photo of the resident's hand, a close up photo of any part of a resident's body or a photo of the back of a resident in the far background of the photo).The facility provided a document titled Cell Phone, Gaming Systems, and Laptop Computers policy with a revision date of 5/21/2026. Purpose-to provide the resident with privacy and dignity & maintain a loving and caring environment without interruptions or distractions in care. Policy - Cell phones, gaming systems and laptop computers are not allowed in the facility. If your children, family, or school needs to contact you, they are welcome to call here, as they always have been able to do in the past. Due to Federal HIPPA Privacy Laws and cell phones having cameras, this policy has become necessary. There is no tolerance or leeway regarding this policy.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 when facility staff had taken a video on their cell phone of Resident #4 and shared it with a snapchat group chat. The facility reported a census of 70 residents.Findings include:The facility corrected the deficient practice per past noncompliance on 5/22/2026 through the following action: -all facility staff educated on the facility's Abuse PolicyAccording to a significant change MDS assessment tool with a reference date of 2/28/2026 documented Resident #4 had a BIMS score of 5. A BIMS score 5 suggested severe cognitive impairment. The MDS documented he required supervision or touching assistance for toileting hygiene, was independent to go from a sitting to standing position and toilet transfers. The MDS documented he was occasionally incontinent of urine and frequently incontinent of bowel. The MDS listed the following diagnoses for Resident #4: encephalopathy, cancer, benign prostatic hyperplasia, renal failure, urinary tract infection (UTI), dementia, depression, and neutropenia.A Care Plan Focus Area with a revision date of 4/6/2026 documented Resident #4 was independent without assisted devices for transfers and ambulation.A Progress Noted documented on 4/1/2026 at 12:37 PM documented Resident #4 was discharged to another facility's memory care unit.The facility investigative file included the following:-on 5/20/2026 Staff G Certified Nursing Assistant (CNA) signed and dated the following typed statement: I was walking into the locker room at school when Staff I CNA said Hey look at this and she had put her phone in front of me. It was a video of a male resident; I don't remember his name. He was standing in the chapel with his back to the chapel door and I could hear him peeing into the trashcan as the video zoomed in on him. Staff I's face was also halfway in the photo. We both laughed, then the bell rang so I left to go to class. I don't remember how long ago it happened, probably over a month ago. I did not report it because I did not feel like I saw anything inappropriate in the video because he was fully dressed.-Staff G was questioned as to why she did not report this at the time. Staff G stated she did not feel like it was something that needed to be reported because he was fully dressed and didn't see anything inappropriate. She did acknowledge that she had taken the mandatory reporting class as well as training upon hire. Immediate education done with Staff G on dependent adult abuse reporting and if she ever questioned whether it is something that should be reported to always just report to your supervisor.-Summary of Findings: the Director of Nursing (DON) was notified by Staff H Registered Nurse (RN) on 5/19/2026 at approximately 8:45 PM that Staff G had notified her of a video she seen on another employee's phone. The video was of a male resident urinating in a trashcan in the chapel. The DON called Staff G on 5/19/2026 at approximately 9:30 PM to confirm. Staff G reported that she was in the locker room at school, she could not remember the date but reports it was over a month ago, when Staff I showed her the video. Staff G stated the video was of half of Staff I's face with a male resident in the background with his back to the camera. Staff G stated that she could hear him urinating but there was no context on the video. Staff G stated the man was fully clothed. The DON did check the CNA schedule and confirmed Staff I was not on the schedule for that evening, late night or the next morning. No resident assessment completed as Resident #4 had been discharged to an assisted living facility closer to facility on 4/1/2026. The DON and Social Worker entered information about Resident #4 on 5/20/2026 at approximately 9:00 AM. The DON asked if Staff I knew why they were interviewing her and she said yes, I think so. Staff I was asked if she ever sent a video of residents to anyone and she said, yes. Staff I acknowledged the video was of a male resident urinating in a trash can in the chapel and she said yes. Staff I stated she sent the video in a snapchat group consisting of 5 other CNAs at the facility. Staff I stated she no longer had the video on her phone. The DON questioned Staff I on how she was able to show the video to someone at a later time in the school locker room that was not in a snapchat group if it was not saved on her phone. Staff I stated I don't remember but the video is not on my phone anymore. Staff I was asked if there were (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any other residents in the video, she stated no just him. Staff I stated she was sitting in center lobby; I turned my phone camera to selfie mode and I could see Resident #4 standing inside the chapel door peeing in a trashcan with his back to her. He was completely dressed, there was no nudity in the photo at all. Staff I stated the photo was taken a while ago, like months ago. Staff I was re-interviewed on 5/22/2026 at 11:10 AM due to having more questions, her changes regarding the incident. When asked what the video was of, she stated myself and a caption that stated Resident #4 is peeing in the trash can. She denied zooming in on the trash can and that she was sitting outside the chapel with another resident. At that time, she heard someone starting to pee in the trash can. Staff I stated she could not remember exactly but did not think Resident #4 was at all visible in the video. Staff I was terminated on 5/20/2026.-The facility's cell phone policy was updated on 5/21/2026. An all-staff in-service was completed on 5/21/2026 related to recent incidents, again discussing the abuse policy, social media policy, HIPPA, and went over the updated cell phone policy. Those staff that were not present at the in-service are being visited with 1-1 by administration. On 5/28/2026 at 9:35 AM Staff E CNA stated if someone showed her a photo of a resident on their phone, she would take it to her supervisor.On 5/28/2026 at 9:45 AM Staff J CNA stated if someone were to show her a photo of a resident on their phone, she would immediately report it to the DON, Assistant Director of Nursing (ADON) or Administrator. She added even if the photo did not have an identifying characteristic of a resident, she would still report it.On 5/28/2026 at 9:51 AM Staff H Registered Nurse (RN) stated she received a text from a staff member about an incident and she told that staff member it needed to be reported. Staff G came up to another staff member and asked if they were part of a group snapchat because apparently, they send photos and videos of residents all the time. Staff H called the DON to tell her what she was informed of regarding the group snapchat. Staff H stated she did not see any photos or videos, just that she was told they sent them in a snapchat group. She stated she would immediately report it if someone sent or showed her a photo of a resident. They have provided education to staff on the reporting requirements.On 5/28/2026 at 10:25 AM Staff C CNA stated if someone showed her a photo of a resident on their phone, she would speak up and go to the charge nurse to report it.On 5/28/2026 at 10:29 AM Staff D CNA stated if she was aware of a staff member with a photo of a resident on their phone, she would report it to the DON or ADON as soon as possible (ASAP).On 5/28/2026 at 10:44 AM Staff F CNA stated if someone sent her or showed her a photo of a resident, she would take that person to the charge nurse, DON, or Administrator. She would remove that staff person from the room so they could not take more photos. If one was sent to her, she would go to the charge nurse.On 5/28/2026 at 10:59 AM Staff G stated she was in the high school locker room when Staff I said look at this, it's funny. On Staff I's phone was a video of a male peeing in a trash can in the chapel at the facility. The school bell rang, so she went to class. She did not recognize the male, he was fully clothed, there were no other resident present. This video was on Staff I's snapchat app and did not say if she had sent it to anyone. Staff G acknowledged she did not tell anyone about this. She stated from the time she saw the photo to the time it was reported to the facility it was probably longer than a month. She did not see any naked parts of the man and did not feel it was severe enough issue to report it.On 5/28/2026 at 12:42 PM Staff B Registered Nurse (RN) stated if someone were to show her a photo or video of a resident on their phone, she would take the phone away, remove the staff member immediately then call the DON, then send the staff member home.On 5/29/2026 at 11:23 AM the DON stated Staff H had called her at home on 5/19/2026 to let her know there is a snapchat group they had an inappropriate picture in it and just wanted her aware. The DON called the Assistant Administrator to inform him. They called Staff G and she stated she was in the school locker room when Staff I said look at this. Staff I got her phone out and showed a video of a guy in the background and Staff I's face in the frame. The guy was peeing in a trash can in the chapel. The video zoomed in on the trash can but the guy was fully dressed and had his back to the phone. When they asked Staff G why she did not report it she told them she did not see any nudity so she did not feel like it needed to be reported. The DON let her (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165269	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearview Home	406 West Washington Mount Ayr, IA 50854

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	know that if she ever had a question about whether something should be reported, to report it.The facility provided a document titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting policy. All allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative.