| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165626 | A. Building<br>B. Wing | 03/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oakview Nursing & Rehablitation - Marion | 720 Oakbrooko<br>Marion, IA 52302 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on observation, clinical record review, facility documentation, interviews, and policy review the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act. A Certified Nurse's Aide (CNA) and a nurse became aware of allegations of abuse and did not report to facility management or the designated state agency. When the facility became aware of an allegation of abuse, they didn't report it to the state agency in a timely manner for 1 of 4 residents reviewed (Resident #2). The facility reported a census of 39 residents.Findings include:The Minimum Data Set (MDS) for Resident #2 dated 11/20/25 identified a Brief Interview for Mental Status (BIMS) score of 15/15 indicated intact cognition. The MDS included diagnoses of multiple sclerosis ( MS, an autoimmune disease that affects the nerves that effects coordination, memory, and emotions), dysarthria (speech disorder caused by muscle weakness), and anarthria (motor speech disorders affecting muscle control), and chronic pain. On 3/9/26 at 11:14 AM observed Resident #2 in bed propped up on pillows. She lifted her left arm and then it dropped to the bed against the side rail. she said was for holding during cares. She stated they (her arms) 'flop around' all of the time due to her disease (multiple sclerosis/MS). She pointed out her new glasses as the interview started. Resident #2 reported a staff member broke her old pair of glasses during cares. Resident #2 said as a CNA cleaned her, she asked her to hold the rail. She stated she couldn't because of her disease and they flipped her too hard which caused her head to bump the rail and break her glasses. She said the staff wore ?these things in their ears' for music, talked about their boyfriends, and didn't listen to her. She stated 'one girl' swatted her shoulder to make her let go as she held on to the rail when she felt like she was falling. She thought she just had to go with the flow when things happened because she couldn't move or get up. When asked if she reported her concerns, Resident #2 said it was her choice whether or not to report and she was capable. She indicated she told a CNA someone hit her shoulder and later told another staff person who used to come visit her (Staff A, Activities Assistant). She stated it came down to the fact that everything hurt because of the MS and staff needed to be more careful.Documents titled Record of One-on-One Activities noted the following:1/2/26 - Resident #2 shared concerns with Staff A that were passed on to management1/12/26 - Resident #2 shared concerns with Staff A that were passed on to nursing1/12/26 - Resident #2 shared concerns with Staff A that were passed on to the Life Enrichment Director (Staff B) and the MDS Coordinator.1/13/26 - Resident #2 shared concerns with Staff A that were passed on to Staff BThe facility provided a summary document dated 1/29/26 regarding Resident #2's concerns which documented the following timeline:a. 1/2/26 - no documentationb. 1/12/26 -The Assistant Director of Nursing (ADON) met with Resident #2 about a CNA who accidentally spilled urine on her nightgown and said it was painful to have it changed. c. 1/13/26 - Staff A reported to Staff B, Resident #2 said staff were rude to her, when they rolled her, she felt like she would fall, and staff would ?smack' her for holding on. Resident #2 stated staff still did this and it was best to go with the flow because when she complained they ignored her. She stated the person still worked at the facility. She did not say who the person was, when it occurred, or what was ?rude.' Resident #2 later reported to the Administrator that she did not say hit and that<br>(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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | her arms flop around due to her disease. d. 1/15/26 - During a meeting with Staff A the Administrator acknowledged the complaint Staff A reported to Staff B for Resident #2. e. 1/16/26 - Staff A notified Staff B and the Administrator she reported Resident #2's abuse allegation to an outside agency.f. 1/25/26 - On 1/22/26 Staff F was interviewed about the current allegation of abuse. She indicated she was not aware of any abuse and Resident #2 had not reported someone slapped her. On 1/25/26 Staff F recalled a conversation with Resident #2 from December. Staff F asked Resident #2 if the current investigation was related to the incident she had reported to her in December, including that someone had done something to her. Resident #2 confirmed it was the same and the staff still worked at the facility. g. Dependent Adult Abuse training was provided to the staff and completed on 1/29/26.An incident report for Resident #2 dated 1/25/26 documented a CNA reported someone hit her in the arm in December.A document titled Statement, signed by Staff F on 1/28/26, recorded Resident #2 told Staff F in December 2025, someone did something to her, and Staff F did not report it. The Statement corroborated the facility's summary.The personnel file for Staff F, reviewed 3/10/26, indicated she successfully completed Dependent Adult Abuse Mandatory Reporter training on 11/4/23, 6/18/24, 5/20/25, and 1/27/26. A Disciplinary Report Form dated 1/27/26 documented the employee failed to report dependent adult abuse in a timely manner.An interview with Staff A on 3/9/26 at 3:41 PM revealed she was upset after Resident #2 reported the allegations to her so she went to her boss. She stated if it were her mother or grandmother, she would want the allegations reported. She was worried the report would be brushed off because the last time she went to them about Resident #2 they (Staff B and the Administrator) said they didn't want to hear it anymore and that made her feel uncomfortable. On 3/10/26 at 2:08 PM Staff B stated Resident #2 and Staff A hit it off and Staff A went in for 1:1 visits. The first time there was a concern (Monday 1/12/26), Staff A reported Resident #2 said someone hit her. During the facility follow up, Staff B said Resident #2 denied saying she was hit but that when staff rolled her for cares her arms flopped and she was afraid of falling. The next day Staff B said Staff A came to her again because Resident #2 alleged she was being abused and they took that seriously. She thought that happened on 1/13/26. She confirmed with Staff A that Resident #2 used the word abused. She stated the Administrator started a full investigation of the abuse allegation.A document provided by the facility that listed Self-Reports to the department did not include a report submitted on 1/13/26. On 3/11/26 at 11:56 AM Staff C, Licensed Practical Nurse (LPN), stated she learned about the allegation in report. In February, Staff C asked Resident #2 about the incident. Resident #2 told her that CNAs broke her glasses and upset her, and Resident #2 named them. The nurse did not follow up with the CNAs, the Director of Nursing (DON), or the Administrator.During an interview on 3/11/26 at 12:09 PM Staff G, CNA, stated Resident #2 never complained to her about broken glasses or staff hurting her. She did not hear about the allegation from anyone else and she was not asked if she was involved.On 3/11/26 at 1:32 PM the Administrator confirmed the summary information provided and that Staff F failed to follow the facility's abuse reporting policy. She stated she did not report the abuse allegation to the department on 1/13/26 because she spoke to Resident #2 herself and thought it was more of a medical and health issue. They reported on 1/25/26 when Staff F told them Resident #2 made the initial statement in December. The Administrator stated they (she and the DON) didn't know about Resident #2's report that staff broke her glasses until an interview with Resident #2 the day before. She expected the staff to notify a supervisor immediately with any allegation of abuse or care concerns.A policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy updated July 2024 documented all residents had the right to be free from abuse. All allegations of abuse or mistreatment should be reported immediately to the charge nurse who was responsible for reporting to the Administrator. All allegations of mistreatment should be reported to the Iowa Department of Inspections, Appeals, and Licensing not later than 24 hours after the allegation was made. |