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	02/12/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews and facility policy review the facility failed to accurately document a skin assessment for 1 of 3 residents (Resident #1) reviewed with a pressure ulcer. The facility also failed to complete proper hand hygiene while completing a treatment to Resident #1's pressure ulcer. The facility reported a census of 35 residents. Findings include:According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 12/11/2025 documented Resident #1 had a Brief of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented he did not reject evaluation or care during the 5-day review period. Resident #1 had impairments to bilateral lower extremities and utilized a wheelchair. Resident #1 was dependent on staff for toilet hygiene, lower body dressing, and chair/bed to chair transfer. He required partial/moderate assistance of staff for rolling left to right. The MDS documented he had a urostomy and was always incontinent of bowel. The MDS documented he did not have a pressure ulcer/injury, was at risk for developing pressure ulcers/injuries and did not have one or more unhealed pressure ulcers/injuries. The following diagnoses was listed for Resident #1: neuromuscular dysfunction for bladder, renal failure, paraplegia, neurogenic bowel, and chronic pain.The Care Plan Focus Area with an initiated date of 12/17/2025 documented Resident #1 had impaired skin integrity and is at risk for edema, skin/tissue color changes, swelling, pain and pressure ulcers related to a diagnosis of paraplegia. Resident #1 had a recurrent stage 4 pressure wound to his left gluteal crease. Staff were instructed to administer treatments as ordered, encourage Resident #1 to shift weight every 2 hours to assist with skin integrity, monitor/document location, size and treatment of skin injury. The Care Plan documented Resident #1 was noncompliant with recommended time frames of being in his wheelchair and removal of the mechanical lift sling while in bed. Resident #1 had an alternating pressure reduction mattress to his bed and a cushion on his wheelchair.A Weekly Nursing Skin assessment dated [DATE] documented Resident #1 did not have any alterations in skin integrity. A small blister was charted yesterday, no new skin issues noted.A Weekly Non-Pressure Wound assessment dated [DATE] at 2:09 PM documented a ruptured blister on his inner aspect of his upper right hip. The assessment documented only 1 of this type was present. The document did not have additional wounds listed. The documented was completed by Staff A previous Assistant Director of Nursing (ADON)/Wound Nurse.Record review revealed the following Progress Note was documented on 1/9/2026 at 11:21 PM: this nurse went in to completed a neurogenic bowel treatment and observed a skin impairment to his right gluteal fold. Resident #1 had an open area with predominantly granulated tissue, borders defined, periwound skin with peeling/excoriation, small amount serosanguineous drainage with purulent drainage noted. There was no foul odor. Wound measured as 4.5 (centimeters) cm x 5.0 cm x 0.2 cm to inner right gluteal fold. This nurse cleansed wound, packed wound with moistened collagen pad, applied mepilex dressing, reinforced with medipore tape and signed and dated dressing.On 2/12/2026 at 10:35 AM Staff A RN and Staff C Agency RN (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed Resident #1's neurogenic bowel treatment and dressing change to his left gluteal fold. They both washed their hands. Staff A came out of the bathroom, put her hair in low ponytail then donned a gown and pair of gloves. Staff A scratched her scalp, picked up a packet of adult wipes that fell on the floor. She then picked up the trash can that was by his dresser and moved it closer to his bed. Staff A and Staff C completed his neurogenic bowel treatment with stool present. They both doffed their gloves and donned a new pair of gloves. Staff failed to complete hand hygiene prior to donning a new pair of gloves. Staff A removed the old dressing to his left gluteal fold, doffed her gloves and donned a new pair without completing hand hygiene. She cleansed the area with saline with her right hand, making his skin taunt with her left hand, doffed her gloves and donned a new pair without completing hand hygiene. Staff A applied no skin barrier around the area, doffed her gloves and donned a new pair without completing hand hygiene. Staff A completed the treatment, doffed her gloves and donned a new pair without completing hand hygiene. She placed a gauze and Tegaderm dated and initialed. After she repositioned Resident #1 in bed, she doffed her gown and gloves then washed her hands. On 2/11/2026 at 11:20 AM Staff A stated the weekly nursing skin assessments are to have any new wounds documented on it, as well as existing wounds and treatments. These were to be done by the nurses working on the floor that day. When asked how the weekly non-pressure wound assessments are completed, she stated with the new company that took over they had not trained them on what was to be done. They were just expected to know things. There was no training or communication about these assessments. When asked how skin assessments are to be completed, she stated their previous policies said a head-to-toe assessment had to be completed. At least that's how she was trained. When asked about the weekly non-pressure assessment that she completed on 1/9/2026 at 2:09 PM she stated she actually completed that on the 7th but did not change the date. She just saw the blister on his hip. He had an old wound on his fold and was healed. When residents have healed wounds, they are to be followed for 2-3 weeks. When she did her assessments, she would only look at the areas of concern. If a new skin area were to develop the nurse would communicate that after they complete their assessment. She would focus on wounds that are known about and present.On 2/11/2026 at 11:27 AM Staff D Registered Nurse (RN)/Wound Nurse) stated the weekly nursing skin assessments are completed weekly by the nurse working on the floor. They are to look and document all old skin issues and anything new. A weekly non-pressure wound assessment is to be completed by the wound nurse. They are to look at the current and new wounds. Essentially, they are to look at all the wounds that is on the resident as that is part of their wound tracking. When asked how these assessments are to be completed, she stated it's a head-to-toe assessment, they should be removing their clothes. She saw the resident's wound on 1/10/2026 prior to his family taking him to the emergency room (ER). She stated with his condition, you had to move his skin around because he had a lot of loose skin. There was scarred tissue surrounding the wound and the center was opened with beefy red tissue exposed. She added there was some drainage noted.On 2/12/2026 at 10:06 AM the Director of Nursing (DON) stated the weekly nursing skin assessments should be done after looking at everything. With the new company taking over they have changed things but have done education on those changes. She stated with Resident #1 that spot on his left gluteal fold should have been noticed on the weekly skin assessment. These assessments are usually done on their bath days so every area is assessed. The pressure and non-pressure assessments are to be completed by the wound nurse, since the new company took over in November. They are to round on residents once a week, look at the wound(s) and obtain measurements. When Staff A completed the assessment that was documented on 1/9/2026 she should have looked at the healed areas as well. Her personally opinion any resident that is a quadriplegic or paraplegic we should be looking at their (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bottom. She added she could see how that spot got missed because you have to move the skin up to visualize it. During a follow up assessment on 11:36 AM she was asked when hand hygiene should be completed during pressure ulcer/wound treatments she stated prior to entering the room, after getting the resident set up and ready for the treatment, after setting up the treatment supplies, after removing the old dressing, once the treatment is completed, after applying a new adult brief and once she was all done, she would wash her hands, basically between glove changes. The DON stated she cares hand sanitizer in her pocket so she probably over does it with hand hygiene.The facility provided a document titled Skin Assessment with an implemented date of 12/5/2025. The documented indicated it is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment.Policy Explanation and Compliance Guidelines:1.A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days and weekly thereafter.7.Documentation of skin assessment:b) document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.)c) document type of woundd) describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain).f) document other information as indicated or appropriate.The facility provided a document titled Hand Hygiene with an implemented date of 12/5/2025. The document indicated all staff will perform proper hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.