STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165313	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Specialty Care	200 16th Avenue East Albia, IA 52531

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, clinical record review, staff interview, and facility policy review the facility failed to perform appropriate hand hygiene during personal cares for one of two residents observed for toileting hygiene (Res #3). The facility reported a census of 50 residents.Findings include:The Minimum Data Set of Resident #3 dated 8/20/25 coded the resident dependent for toileting hygiene. The MDS reflected the resident always incontinent of urine and bowel. The MDS documented diagnoses that included non Alzheimer's dementia and Parkinson's Disease. The Care Plan of Resident #3 documented the resident to always have urinary incontinence and frequent bowel incontinence, dated 5/5/25. On 9/3/25 at 8:51 am, Resident #3 was in the dining room finishing breakfast. A puddle of urine was noted to be on the floor underneath his wheelchair.On 9/3/25 at 9:06 am, Staff A, Certified Nurse Aide (CNA) cued Resident #3 to put his feet up on his wheelchair foot pedals to take him to his room. When she noted the urine, she notified another staff member for it to be cleaned. Observation of incontinence cares began on 9/3/25 at 9:07 am. Staff A stated Staff B, CNA would also be assisting her as Resident #3 was a heavy assist to stand and transfer to bed. After pushing Resident #3 in his wheelchair into his room and closing the door, Staff A and Staff B both washed their hands and donned isolation gowns and disposable gloves. Staff A stated the resident required isolation gowns due to wounds on his legs. Staff A, wearing gloves, repositioned the wheelchair for a safe transfer as Staff B turned down the bedding on the bed. Staff B then removed the foot pedals from the wheelchair as Staff A locked the brakes on the wheelchair. Staff B then placed a gait belt (a belt worn around a patient's waist to assist with walking and transfers) around the resident's waist. Staff gave step by step instructions as his walker was placed in front of him. Staff stood on either side of Resident #3, holding the gait belt and guiding him safely to a standing position and transferring him to the bed. The wheelchair cushion was soiled with urine. The resident was positioned on the bed on top of a disposable bed pad. Staff A opened the closet and obtained a clean incontinence brief, wipes and clean clothing. With no glove changes or hand washing, Staff A assisted Res #3 to turn to his left side, and lowered his pants and pull up style incontinence brief, turned him to his right side to continue to lower his clothing. Staff B opened a plastic bag and Staff A placed his soiled clothing in the bag and tore the side of the incontinent brief to fully open the brief. Staff A then used disposable wipes to cleanse his abdomen and then groin area with separate wipes. On 9/3/25 at 9:18 am, staff assisted the resident to turn to his right side and then cleansed his buttocks and disposed of the soiled brief. Staff tucked the soiled under pad underneath the resident and placed a clean under pad in it's place. Staff turned the resident to assist in getting the pad in place. Staff B placed a clean pull up style brief over Res #3's feet and positioned it in place. Staff B then placed clean shorts on him and repeated the process until he was dressed. Staff B placed boundary identifying wedges on the bed near the resident and placed his sheets and blanket over him. She then used the remote control of the bed to place the bed in a safe position. Staff A then removed her gown and gloves and washed her hands. Staff B obtained the call light for the resident and placed it in his reach and then removed her gown and gloves and washed her hands.On 9/3/25 at 9:24 am Staff A placed clean gloves on her hands. She gathered the soiled clothing from the room and Staff B placed the soiled wheelchair in the bathroom and shut the bathroom door. She folded his walker and (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placed it near the bedside table. Staff A placed the garbage in the biohazard trash box in the room and placed a clean trash liner in the can. She then turned off the room light and exited the room. On 9/3/25 at 9:32 am, the Director of Nursing (DON) stated the resident's wheelchair should have been cleaned and staff should change gloves and wash hands between dirty and clean tasks. The facility policy Handwashing/Hand Hygiene, revision date August 2019 documented the following:Point 7: Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:a. Before and after coming on duty;b. Before and after direct contact with residents;c. Before preparing or handling medications;d. Before performing any non-surgical invasive procedures;e. Before and after handling an invasive device (e.g., urinary catheters, IV access sites);f. Before donning sterile gloves;g. Before handling clean or soiled dressings, gauze pads, etc.;h. Before moving from a contaminated body site to a clean body site during resident care;i. After contact with a resident's intact skin;j. After contact with blood or bodily fluids;k. After handling used dressings, contaminated equipment, etc.;l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident;m. After removing gloves;n. Before and after entering isolation precaution settings;o. Before and after eating or handling food;p. Before and after assisting a resident with meals; andq. After personal use of the toilet or conducting your personal hygiene.