STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165365	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care Center	400 Highway 18 West Clear Lake, IA 50428

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and facility change in condition form, at the time of the investigation, the facility failed to assess lung sounds, after a resident had an emesis for which resulted with the resident being admitted to the hospital on [DATE] with septic shock (a life threatening condition that occurs when an infection spreads throughout the body and causes a drop in blood pressure that cannot be corrected with fluids alone) related to aspiration pneumonia (a type of lung infection that is due to a relatively large amount of material from the stomach or mouth entering the lungs) for 1 of 3 residents reviewed (Resident #4). The facility identified a census of 62 residents. Findings include:Findings include:The Minimum Data Set (MDS) for Resident #4 with an assessment reference date of 9/8/25, documented diagnoses for which included hypertension, seizure disorder, anxiety, depression and dysphagia (difficulty swallowing and can affect a person ability to safely and easily move food or liquid from the mouth to the stomach). The MDS revealed the resident had short- and long-term memory impairments and moderately impaired for decision making abilities, rarely understands and rarely makes self-understood. The resident required dependent assistance for activity of daily living (ADL) for which included eating assistance. The MDS documented no behaviors.The Plan of Care with a target dated 12/1/25, revealed the resident requires assistance with activity of daily living and potential/actual risk for altered nutritional status, provide diet as ordered, monitor weights, the resident requires one-to-one (1-1) feeding assistance, the resident is dependent on staff for oral care/personal hygiene. The Alert Note dated 10/6/25 at 8:21 PM, revealed Resident #4 was found with emesis (the action or process of vomiting) on her gown, her hair, face, mouth swept (an act to attempt to clear the mouth) to assist her, she continued to cough and have emesis for several minutes, once emesis stopped, vitals were with in normal limits, cleaned her up, she is in recliner resting with eyes closed, even respirations, continue 72 hour follow up report after choking.The Alert Note dated 10/7/25 at 10:18 AM, revealed, overnight nurse reports that resident had no further emesis during the night. This AM, resident did not swallow medications. She also refused to drink her supplement. Resident was not making eye contact with staff. She was not reacting to voice. No coughing noted since resident got up in rock-in-go wheelchair. Lungs have crackles in the bases bilaterally. Respirations are 46 breathes per minute and somewhat labored. Nail beds are cyanotic (a bluish color caused by inadequate oxygen level in the blood). Fingers are cool to touch. The Transfer to Hospital Summary dated 10/7/25 at 10:48 AM, revealed that the reason for transfer is tachypnea (abnormally fast breathing rate)(can be a sign of a serious medical issue like sepsis) not responding, vomited while laying down last night. The Shift Follow up to Incident Note dated 10/7/25 at 12:22 PM, revealed vomiting/choking while laying down, resident transferred to the Emergency Department. Respirations 46 breathes per minute, crackles in the bases of lungs, non-responsive.The Interact Transfer Form dated 10/7/25 at 10:48 AM, revealed reason for transfer: possible aspiration pneumonia.The Progress Notes with date of service 10/13/25 at 7:20 AM, documented, principal problem of septic shock. Resident #4 was admitted to Critical Care Unit (CCU) on 10/7/25 for Septic Shock. Per nursing staff the patient was found with vomit in her mouth and was not at her baseline. They also report that she was hypotensive (condition where the blood (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure is significantly lower than normal). Transition to comfort care. Sepsis secondary to pneumonia.Interview on 10/8/25 at 2:00 PM, Staff A, License Practical Nurse (LPN), acknowledged that the expectation of the nurses are to start a change in condition form in the computer software program for the resident that shows symptoms that are abnormal from their baseline and that form will generate for the next shift to document on that resident.Interview on 10/14/25 at 3:24 PM, Staff B, Registered Nurse (RN), verified that the clinical record lacked documentation of the change in condition form that needed to be completed on Resident #4. The change in condition form will generate follow up documentation of the condition that is charted. The staff are expected to follow the change of condition form.Interview on 10/14/25 at 3:50 PM, Staff C, LPN, verified that the clinical record that documentation of the resident lung sounds after the emesis and acknowledged that the expectation of the nurses is to generate a change in condition form in the computer software.The Change in Condition Form with no date, stated that a change in condition for an assessment of abdominal/gastrointestinal with nausea and/or vomiting needs to be charted on and followed up per guidelines.Emesis in elderly or medically complex residents is a common occurrence and can be triggered by a variety of factors, including medication side effects, acute illness, or even minor GI upset. When emesis occurs, nursing staff must prioritize immediate safety concerns such as airway protection, monitoring for further vomiting, and ensuring the resident is stable. In the absence of overt signs of GI distress or abdominal pain, the initial nursing response may focus on supportive care and observation rather than a full GI assessment.Nursing staff are trained to use clinical judgment to determine when further assessment is warranted. If the emesis episode was isolated, with no associated abdominal pain, distension, or changes in bowel habits, the staff may have deemed it appropriate to monitor the resident for evolving symptoms rather than perform a comprehensive GI assessment at that moment. This approach helps prevent unnecessary interventions and distress for the resident, especially if their overall condition appeared stable following the episode. It is not uncommon for aspiration pneumonia to develop several hours after an aspiration event. At the time of the initial emesis, the resident may not have displayed clinical signs of pneumonia, such as fever, productive cough, or respiratory distress. The development of these symptoms may have occurred later, prompting the decision to send the resident to the hospital for further evaluation and management. Thus, the absence of a GI assessment at the time of emesis does not necessarily represent a lapse in care but rather reflects the evolving nature of the clinical picture.