

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, staff, and resident interviews, the facility failed to treat residents with respect and dignity in a manner that promotes maintenance or enhancement of his or her quality of life for 2 of 7 residents reviewed (Resident #1 and #10). The facility identified a census of 60 residents. Findings include: 1. Resident #10's Minimum Data Set (MDS) assessment dated [DATE] documented Resident #10 usually understands and feels understood, with adequate vision. The MDS documented a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. The MDS documented diagnoses including anemia (low red blood cells), heart failure (weakened heart muscle), renal failure (kidney failure), non-Alzheimer's dementia (memory loss), and depression (mood disorder). The MDS documented Resident #10 required staff dependence for toileting hygiene and dressing, and setup help for personal hygiene. Resident #10's Care Plan dated 8/19/26 identified a focus area for behavior problems related to dementia. Interventions directed staff to approach and speak in a calm manner, assure Resident #10 staff validate concerns and stand willing to address legitimate concerns, and communicate clearly. The Investigation Summary dated 7/19/26 documented Staff B, Registered Nurse (RN), reported overhearing Staff C, Certified Nursing Assistant (CNA), tell Resident #10 to just wet her pants while Staff B stood at the medication cart outside Resident #10's closed bedroom door. Staff B reported overhearing Staff C tell Resident #10 to just wet her pants from behind the closed door approximately two weeks prior. The summary documented Staff D, CNA, remained in the room during the statement, though Staff D reported no recollection of the event or hearing Staff C tell Resident #10 to just wet her pants. On 7/21/26 at 11:50 AM Resident #10 stated feeling upset about an incident where two aides entered the room getting the roommate up for the day. Resident #10 stated needing to go to the bathroom, but Staff C stated Staff C and Staff D remained in the middle of a transfer, telling Resident #10 to urinate in the brief and promising cleanup after finishing with the roommate. Resident #10 stated feeling embarrassed to urinate in a brief and noted staff repeatedly tell Resident #10 to urinate in the brief for later cleanup. Resident #10 stated working with therapy to transfer independently so staff won't need to help with bathroom trips, emphasizing staff need to treat all residents with dignity and respect. 2. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] documented Resident #1 holds the ability to be understood and understand others with no vision problems, behaviors, or resistance of care. The MDS documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented diagnoses including anemia (low red blood cells), cerebral palsy (brain disorder affecting movement), depression (mood disorder), and chronic pain (long-lasting pain). The MDS documented Resident #1 required staff dependence for toileting, personal hygiene, bathing, and dressing, using a wheelchair for mobility. Resident #1's Care Plan dated 8/12/26 identified a (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 165365	If continuation sheet Page 1 of 11

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	focus area for behavior problems, noting Resident #1 tends to reject care, food, medications, and repositioning, consistent with resident values. Interventions directed staff to assure Resident #1 staff validate concerns and stand willing to address legitimate concerns, maintaining respect for Resident #1's rights to make lifestyle choices. The Interdisciplinary Team (IDT) Meeting Notes dated 4/27/26 at 8:25 AM documented Resident #1 expressed disliking new staff and preferring familiar staff as a normal response for Resident #1. On 7/17/26 at 2:00 PM Resident #1 stated Staff A, CNA, isn't nice and doesn't treat Resident #1 with dignity and respect. On 7/23/26 at 12:44 PM the Administrator and Staff E, RN, acknowledged staff must treat all residents with dignity and respect at all times as a facility expectation. The Resident Rights-Dignity and Respect policy dated April 2024 directed staff to lay the foundation for treating all residents with dignity and respect, maintaining and enhancing self-esteem and self-worth. The policy directed each resident holds the right to considerate and respectful care, receiving treatment with honesty, dignity, respect, and reasonable accommodation of individual needs.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident representative interview, the facility failed to notify a resident representative/family following a resident's fall for 1 of 6 residents reviewed (Resident #4). The facility reported a census of 60 residents. Findings include: Resident #4's Minimum Data Set (MDS) assessment dated [DATE] documented short and long-term memory problems with moderately impaired decision-making abilities, the ability to understand and receive understanding from others, and no present behaviors. Resident #4's MDS documented staff dependence for toileting hygiene, upper and lower body dressing, personal hygiene, transfers, and ambulation, alongside two falls without injury. Resident #4's MDS documented medical diagnoses including cancer (malignant growth), diabetes mellitus (high blood sugar), and hypertension (high blood pressure). Resident #4's Care Plan with a cancellation date of 6/30/26 identified Resident #4 at risk for falls, noting Resident #4 doesn't remember to use a walker for long-distance ambulation (walking) and needs reminders. Interventions instructed keeping the bed in a low position, placing the call light within reach, providing new non-skid shoes, and placing a sign reminding Resident #4 to take the walker when ambulating. An Incident Report in progress notes dated 6/17/26 at 11:55 PM documented staff hearing a loud crash. Upon staff entering Resident #4's room, staff discovered Resident #4 lying on the floor on Resident #4's back, positioning Resident #4's head in the corner by the bathroom door, feet toward the middle of the room, and walker beside the end of the bed. Two staff members assisted Resident #4 to standing, placed Resident #4 into a wheelchair, transported Resident #4 to the north lounge, and transferred Resident #4 to a recliner. Staff observed Resident #4 10 minutes prior to the fall and documented plans to notify Resident #4's Family Member in the morning. General Progress Notes dated 6/18/26 at 7:13 AM documented calling Resident #4's wife to provide an update regarding Resident #4's fall. On 7/23/26 at 9:45 AM Resident #4's Family Member stated expecting notification following the fall occurring on 6/17/26 at 11:55 PM. On 7/23/26 at 12:44 PM the Administrator, and Staff E, Registered Nurse (RN), stated nursing staff must notify family members regarding a resident's change of condition, including falls and new or discontinued medications. The Notification for Change of Condition policy dated June 2023 instructed staff to immediately inform the resident and notify the resident's legal representative or an interested family member when an accident involving the resident occurs resulting in injury or holding potential to require physician intervention.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility investigation, facility policy, staff and resident interview, the facility failed to report all alleged violations involving mistreatment and misappropriation of resident's property to the Department of Inspection and Appeals and Licensing (DIAL) within 2 hours for 2 of 2 residents reviewed (Resident #10 and #11). The facility reported a census of 60 residents. Findings include: 1. Resident #10's Minimum Data Set (MDS) assessment dated [DATE] documented adequate vision and a Brief Interview for Mental Status (BIMS) score of 5, indicating severely cognitively impaired. Resident #10 usually understood others and others sometimes understood Resident #10. Resident #10 required staff dependence for toileting hygiene and dressing, setup help for personal hygiene, and experienced frequent urinary incontinence (loss of bladder control). Diagnoses included anemia (low red blood cells), heart failure (weakened heart), renal failure (kidney failure), non-Alzheimer's dementia (memory loss), and depression (mood disorder). Resident #10's Care Plan focus target dated 8/19/26 identified Resident #10 at risk for falls related to confusion. Interventions instructed staff to provide frequent toileting, encourage toileting before and after meals, keep personal care items and call light within reach, and assist Resident #10 with a stand-pivot transfer using 1 staff member and a front-wheeled walker. The Care Plan noted Resident #10 couldn't always express needs due to confusion. The Investigation Summary dated 7/19/26 documented Staff B, Registered Nurse (RN), overheard Staff C, Certified Nursing Assistant (CNA), tell a resident to just wet her pants while Staff B stood at the medication cart in the hallway outside Resident #10's closed bedroom door. During staff interviews, Staff B informed the Director of Nursing of witnessing potential abuse by Staff C toward Resident #10. Staff B reported overhearing Staff C tell Resident #10 to just wet her pants from behind Resident #10's closed door a couple of weeks prior, but couldn't recall the exact date of the incident or report. The summary documented Staff D, CNA, remained in the room when Staff C made the statement to Resident #10, though Staff D reported no recollection of the event or hearing Staff C tell Resident #10 to just wet her pants. The facility suspended Staff C on 7/19/26 pending investigation and provided staff education regarding abuse and reporting procedures. The Statement of Events dated approximately 7/19/26 at 8:00 AM documented on an unknown date approximately 6/25/26 at 9:00 AM, Staff B stopped the Director of Nursing at the nurse's station while Resident #10 sat in a wheelchair nearby. Staff B spoke vaguely, stating Resident #10 reported having to urinate in her pants that morning because an aide did it again, and Staff B assumed Staff C caused it. The Director of Nursing educated Staff B regarding assumptions, clarifying situations, and offering immediate toileting due to Resident #10's cognition. The Director of Nursing returned to the office, then visited Resident #10 in her room to ask if Resident #10 had to pee her pants. Resident #10 stated making it to the bathroom that morning, and the Director of Nursing offered toileting assistance again. The Director of Nursing documented not recalling Staff B's reported statements and denied ever stating being too busy to deal with the situation, recalling instead stating having just arrived from a meeting and needing a moment to gather thoughts for the day. On 7/19/26 at 8:00 AM the Director of Nursing called Staff B for follow-up questions regarding interview responses. Staff B reported notifying the Director of Nursing in person 1 to 2 weeks prior to taking a week off. The Director of Nursing responded not recalling the conversation and requested details. Staff B stated informing the Director of Nursing at the nurse's station about Staff C telling Resident #10 to urinate in her pants, claiming the Director of Nursing responded not having time for it. The Director of Nursing (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted not recalling the interaction that way, but agreed to review and take notes. Staff B stated during a prior incident while passing medications outside Resident #10's closed room door, Staff B overheard Staff C tell Resident #10 from inside the room with Staff D to just pee your pants or similar words. Staff B stated pulling Staff C aside later that day to explain making such statements constituted abuse. Staff B further stated informing the Director of Nursing later when Resident #10 came to the nurse's station stating an aide said Resident #10 had to urinate in her pants again, claiming the Director of Nursing stated an inability to do anything at that time. The Director of Nursing reviewed the conversation with Staff B to confirm accuracy and signed the document. On 7/19/26 at 9:00 AM the Director of Nursing interviewed Staff C over the phone. The Director of Nursing asked Staff C if Staff C ever heard staff or a resident state just pee in your pants. Staff C acknowledged telling Resident #10 approximately a month or longer prior while Staff C and Staff D transferred Resident #10's roommate. Staff C stated Resident #10 expressed an urgent need to use the bathroom, and Staff C responded remaining busy assisting the roommate. When Resident #10 stated an inability to hold urine, Staff C told Resident #10 it felt okay to urinate in her brief and Staff C would clean Resident #10 up after completing the transfer. Staff C stated Staff B stopped Staff C later to explain making such statements constituted abuse. Staff C reported telling Staff B about not telling Resident #10 to just pee in your pants, but rather reassuring Resident #10 about cleaning her up if she couldn't hold it, as Staff C couldn't stop operating a mechanical lift during a transfer. The Director of Nursing reviewed the interview to confirm understanding, determined further investigation felt necessary, and signed the document. On 7/21/26 Staff B provided a written statement documenting during a morning medication pass at the medication cart parked between two rooms, Staff B overheard Staff C tell Resident #10 from behind a closed door to just go to the bathroom in your pants. Staff B noted both Resident #10 and the roommate required two-person assistance for transfers. After passing medications, Staff B entered Resident #10's room and observed Resident #10 sitting on a shower chair draped with a cover while aides finished assisting the roommate. Staff members transported Resident #10 to the shower room for a scheduled shower and then to the dining room for breakfast. Following breakfast, Staff B entered Resident #10's room to administer medications, and Resident #10 repeatedly stated needing to use the bathroom. Staff B informed an aide, who claimed Resident #10 likely used the bathroom during her shower, but Staff B requested the aide assist Resident #10. Later that morning, Staff B informed the Director of Nursing at the nurse's station about Staff C telling Resident #10 to go to the bathroom in her pants. Staff B documented the Director of Nursing asked if Resident #10 used the bathroom, and upon Staff B confirming yes, the Director of Nursing responded caring only about Resident #10 receiving toileting assistance and stating an inability to manage everything personally. Early that afternoon, Staff B pulled Staff C aside privately to report overhearing the statement and explaining telling a resident to go in her pants constituted abuse. Staff B documented Staff C denied making the statement, claiming Staff D made it instead. A written statement by Staff C with no date or time explained approximately 4 weeks prior, Staff B pulled Staff C aside near the medication cart regarding comments made to Resident #10. Staff C attempted to explain Staff B misunderstood the context, but Staff B didn't listen. Staff C explained prior to Resident #10 utilizing a stand-pivot transfer, Staff C and Staff D used a mechanical lift to assist Resident #10's roommate while Resident #10 sat on the bed waiting to transfer to the toilet. When Resident #10 expressed an urgent need to toilet, Staff C and Staff D explained assisting as soon as they finished placing the roommate in a chair. When Resident #10 began urinating in her brief and expressed embarrassment, Staff C reassured Resident #10, noting she wore a brief and staff would clean and change her as soon as they finished with the roommate. On 7/21/26 at 11:50 AM Resident (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#10 stated feeling upset about an incident occurring on an unknown date and time when two aides entered the room to get the roommate up for the day. Resident #10 stated expressing a need to use the bathroom, but Staff C responded remaining in the middle of a transfer, telling Resident #10 to urinate in her brief and promising cleanup after finishing with the roommate. Resident #10 stated feeling embarrassed to urinate in a brief, noting staff repeatedly tell Resident #10 to urinate in her brief for later cleanup. Resident #10 stated working with therapy to transfer independently so staff won't need to help with bathroom trips, emphasizing staff need to treat all residents with dignity and respect. 2. Resident #11's Minimum Data Set (MDS) assessment dated [DATE] documented adequate vision and a BIMS score of 13, indicating intact cognition. Resident #11 possessed the ability to understand others and make self understood. Resident #11 required staff dependence for toileting hygiene, partial to maximal assistance for dressing and personal hygiene, and experienced frequent urinary incontinence (loss of bladder control). Diagnoses included anemia (low red blood cells), heart failure (weakened heart), renal failure (kidney failure), non-Alzheimer's dementia (memory loss), and depression (mood disorder). Resident #11's Care Plan focus target dated 8/1/26 identified Resident #11 required assistance with Activities of Daily Living (ADLs) related to impaired mobility and noted Resident #11 might become upset without warning, exhibiting suspiciousness toward staff and tearfulness. Interventions instructed staff to use a gait belt (safety belt) during transfers and ambulation (walking) and assist with toileting according to Resident #11's routine. The Investigation Summary dated 7/17/26 documented Resident #11 alleged Staff F, Certified Nursing Assistant (CNA), stole collector coins from her drawer and retaliated by bumping Resident #11's wheelchair with another resident's wheelchair and kicking her chair during mealtimes. On 7/17/26 staff overheard Resident #11 telling others about Staff F stealing her coins and retaliating. Staff E, Administrator, submitted a self-report to the state agency regarding potential theft and abuse. Resident #11 informed a police officer about Staff F stealing 50-cent coins totaling at least \$20.00 while Resident #11 used the bathroom around 7/1/26, later changing the date to after 7/4/26 when she stored two shirts in the drawer. Resident #11 stated checking the drawer the next morning after hearing clinking sounds and noticing the coins missing. Resident #11 reported Staff F bumped her wheelchair on 7/10/26 or 7/11/26 and kicked her chair on 7/17/26. On 7/20/26 Staff E called Resident #11 Representative to verify bringing coins to the facility a couple of months prior. Resident #11 Representative inspected coins held by Staff E and denied they represented the missing ones. The summary documented conflicting dates, Resident #11's history of making misplaced property accusations, no resident concerns regarding Staff F, and a lack of evidence identifying Staff F as the source of missing coins. On 7/21/26 at 11:15 AM Resident #11 stated approximately 3 weeks prior, Staff F assisted Resident #11 to the bathroom and closed the door. Resident #11 reported hearing jingling sounds from Staff F's pocket while sitting on the toilet. Resident #11 explained returning to a card game and telling another resident about the jingling sounds, prompting the resident to suggest checking the pink coin purse in Resident #11's room. Resident #11 returned to her room, discovered all coins missing from the coin purse, and didn't mention it initially, but grew angrier over time. On 7/21/26 at 4:00 PM Staff G, Registered Nurse (RN), stated Staff F informed Staff G about Resident #11 accusing Staff F of taking coins from a coin purse. Staff G acknowledged not reporting the allegation to Staff E or the Director of Nursing because Resident #11 frequently made accusations of staff stealing. Staff G explained instructing Staff F to stay away from Resident #11. On 7/21/26 at 4:22 PM Staff E confirmed other residents brought to her attention Resident #11 accusing Staff F of stealing coins from a room drawer. Staff E stated expecting staff to separate involved parties and initiate an investigation immediately, estimating the incident occurred approximately 6/23/26 or 6/25/26. On 7/23/26 at 11:11 (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM Staff E and the Director of Nursing stated they expected all staff to report resident allegations immediately, requiring reports to the Department of Inspections, Appeals and Licensing (DIAL) within a 2-hour timeframe. The Patient Protection Guidelines for Abuse Prevention, Reporting, and Investigation policy dated September 2025 directed staff to provide professional care and services in an environment free from abuse, neglect, misappropriation (theft) of resident property, and exploitation. The policy instructed staff to report all allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin, and misappropriation to DIAL immediately and no later than 2 hours.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure staff treated residents with dignity and respect, failed to document allegations of personal degradation and misappropriation (theft) of property in clinical records, and failed to investigate allegations of potential abuse and misappropriation of property for 2 of 2 residents (Resident #10, Resident #11) reviewed for abuse. The facility reported a census of 60 residents. Findings include: 1. Resident #10's Minimum Data Set (MDS) assessment dated [DATE] documented adequate vision and a Brief Interview for Mental Status (BIMS) score of 5, indicating severely cognitively impaired. Resident #10 usually understood others and sometimes others understood them. Resident #10 required staff dependence for toileting hygiene and dressing, and setup help for personal hygiene. Diagnoses included anemia (low red blood cells), heart failure (weakened heart), renal failure (kidney failure), non-Alzheimer's dementia (memory loss), and depression (mood disorder). Resident #10's Care Plan focus target dated 8/19/26 identified Resident #10 at risk for falls related to confusion. Resident #10's Clinical Record lacked documentation regarding the allegation of personal degradation. The Investigation Summary dated 7/19/26 documented Staff B, Registered Nurse (RN), reported overhearing Staff C, Certified Nursing Assistant (CNA), tell Resident #10 to just wet her pants while Staff B stood at the medication cart in the hallway outside Resident #10's closed bedroom door. Staff B informed the Director of Nursing about witnessing potential abuse by Staff C toward Resident #10. Staff B reported overhearing Staff C tell Resident #10 from behind the closed door to just wet her pants approximately two weeks prior, though Staff B couldn't recall the exact date of the incident or report. The summary documented Staff D, CNA, remained in the room during the statement, though Staff D reported no recollection of the event or hearing Staff C tell Resident #10 to just wet her pants. Facility leadership suspended Staff C on 7/19/26 pending investigation and provided staff education regarding abuse and reporting procedures. The Statement of Events dated approximately 7/19/26 at 8:00 AM documented on an unknown date approximately 6/25/26 at 9:00 AM, Staff B stopped the Director of Nursing at the nurse's station while Resident #10 sat in a wheelchair nearby. Staff B spoke vaguely without clearly describing a situation, stating Resident #10 reported having to urinate in her pants that morning because an aide did it again, and Staff B assumed Staff C caused it. The Director of Nursing educated Staff B regarding assumptions and clarifying exact situations. The Director of Nursing returned to the office, then visited Resident #10 to ask if Resident #10 had to pee her pants. Resident #10 stated making it to the bathroom that morning. The Director of Nursing documented not recalling Staff B's reported statements and denied ever stating an inability to handle the situation due to being too busy. On 7/19/26 at 8:00 AM the Director of Nursing called Staff B for follow-up questions regarding interview responses. Staff B reported notifying the Director of Nursing in person approximately 1 to 2 weeks prior to taking a week off. Staff B stated informing the Director of Nursing at the nurse's station about Staff C telling Resident #10 to urinate in her pants, claiming the Director of Nursing responded not having time for it. Staff B stated during a prior incident while passing medications outside Resident #10's closed room door, Staff B overheard Staff C tell Resident #10 from inside the room with Staff D to just pee your pants or similar words. Staff B stated pulling Staff C aside later that day to explain making such statements constituted abuse. Staff B further stated informing the Director of Nursing later when Resident #10 came to the nurse's station stating an aide said Resident #10 had to urinate in her pants again, claiming the Director of Nursing stated an inability to do anything at that time. On 7/19/26 at 9:00 AM the Director of Nursing interviewed Staff C over the (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	phone. Staff C acknowledged telling Resident #10 approximately a month or longer prior that it felt okay to urinate in her brief and Staff C would clean Resident #10 up after completing a transfer. Staff C stated Staff B stopped Staff C later to explain making such statements constituted abuse. The Director of Nursing determined further investigation felt necessary. On 7/21/26 Staff B provided a written statement documenting during a morning medication pass, Staff B overheard Staff C tell Resident #10 from behind a closed door to just go to the bathroom in your pants. Later that morning, Staff B informed the Director of Nursing at the nurse's station about Staff C telling Resident #10 to go to the bathroom in her pants. Staff B documented the Director of Nursing asked if Resident #10 used the bathroom, and upon Staff B confirming yes, the Director of Nursing responded caring only about Resident #10 receiving toileting assistance and stating an inability to manage everything personally. Early that afternoon, Staff B pulled Staff C aside privately to report overhearing the statement and explaining telling a resident to go in her pants constituted abuse. A written statement by Staff C with no date or time explained approximately 4 weeks prior, Staff B pulled Staff C aside near the medication cart regarding comments made to Resident #10. Staff C explained telling Resident #10 staff would clean and change her as soon as staff finished with a roommate transfer. On 7/21/26 at 11:50 AM Resident #10 stated feeling upset about an incident where Staff C told Resident #10 to urinate in her brief during a transfer. Resident #10 stated feeling embarrassed to urinate in a brief, noting staff repeatedly tell Resident #10 to urinate in her brief for later cleanup. 2. Resident #11's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Resident #11 possessed the ability to understand others and make themselves understood with adequate vision. Resident #11 required staff dependence for toileting hygiene, and partial to maximal assistance for dressing and personal hygiene. Resident #11's MDS documented diagnoses including anemia, heart failure, renal failure, non-Alzheimer's dementia, and depression. Resident #11's Care Plan focus target dated 8/1/26 identified Resident #11 required assistance with Activities of Daily Living (ADLs) related to impaired mobility. Resident #11's Clinical Record lacked documentation regarding the allegation of misappropriation (theft) of personal property. The Investigation Summary dated 7/17/26 documented Resident #11 alleged Staff F, CNA, stole collector coins from her drawer. On 7/17/26 staff overheard Resident #11 telling others about Staff F stealing her coins. The Administrator submitted a self-report to the state agency regarding potential theft. Resident #11 informed a police officer about Staff F stealing 50-cent coins totaling at least \$20.00 while Resident #11 used the bathroom around 7/1/26. On 7/20/26 the Administrator called Resident #11 Representative to verify bringing coins to the facility. The summary documented conflicting dates and a lack of evidence identifying Staff F as the source of missing coins. On 7/21/26 at 11:15 AM Resident #11 stated approximately 3 weeks prior, Staff F assisted Resident #11 to the bathroom, and Resident #11 heard jingling sounds from Staff F's pocket. Resident #11 discovered all coins missing from the pink coin purse in her room. On 7/21/26 at 4:00 PM Staff G, RN, stated Staff F informed Staff G about Resident #11 accusing Staff F of taking coins from a coin purse. Staff G acknowledged not reporting the allegation to the Administrator or the Director of Nursing because Resident #11 frequently made accusations of staff stealing. Staff G explained instructing Staff F to stay away from Resident #11 rather than initiating an investigation. On 7/21/26 at 4:22 PM the Administrator confirmed other residents brought to her attention Resident #11 accusing Staff F of stealing coins from a room drawer. The Administrator stated expecting staff to separate involved parties and initiate an investigation immediately, estimating the incident occurred approximately 6/23/26 or 6/25/26. The Administrator confirmed staff must start an investigation immediately and keep the resident safe. On 7/23/26 at 11:11 AM the Administrator and (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Director of Nursing stated expecting all staff to report resident allegations immediately, requiring reports to the Department of Inspections, Appeals and Licensing (DIAL) within a 2-hour timeframe. The Patient Protection Guidelines for Abuse Prevention, Reporting, and Investigation policy dated September 2025 directed staff to provide professional care and services in an environment free from abuse, neglect, misappropriation (theft) of resident property, and exploitation. The policy instructed the facility to maintain evidence of thoroughly investigating all alleged violations and preventing further potential abuse while investigations remain in progress. The policy directed the center to conduct a timely, thorough, and objective investigation of potential abuse indicators once reported.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Oakwood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Highway 18 West Clear Lake, IA 50428	
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff, and resident interviews, the facility failed to have two staff always available to use the EZ-stand (sit-to-stand mechanical lift) to transfer residents for 1 of 4 residents reviewed (Resident #2). The facility reported a census of 60 residents. Findings include: Based on observation, record review, and interview, the facility failed to ensure staff members utilized two staff members during mechanical lift transfers for Resident #2. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Resident #2 possessed adequate vision, the ability to understand others, and the ability to make self understood, and didn't exhibit behaviors or resistance to care. Resident #2 required staff dependence for toileting hygiene, dressing, and transfers, alongside setup help for oral and personal hygiene. Resident #2's MDS documented diagnoses including hypertension (high blood pressure), non-Alzheimer's dementia (memory loss), depression (mood disorder), and muscle weakness (loss of muscle strength). Resident #2's Care Plan with a target date of 8/12/26 identified a focus area for assistance with Activities of Daily Living (ADLs) related to a history of stroke (brain blood flow blockage) impacting the left dominant side of the body. Interventions instructed staff to transfer Resident #2 using an EZ-stand (sit-to-stand mechanical lift) with two staff members. On 7/21/26 at 10:45 AM an observation revealed Staff H, Certified Nursing Assistant (CNA), and Staff I, CNA, attached the EZ-stand to Resident #2 by the loops on the sling. Staff H and Staff I transferred Resident #2 from the recliner to the wheelchair. On 7/21/26 at 11:00 AM Resident #2 stated staff members sometimes use the EZ-stand with only one staff member present. On 7/22/26 at 10:00 AM Staff J, Licensed Practical Nurse (LPN), confirmed staff members sometimes use the EZ-stand with residents using only one staff member. Staff J confirmed the facility requires two staff members at all times when using mechanical lifts and EZ-stands. On 7/22/26 at 12:00 PM Staff B, Registered Nurse (RN), stated hearing staff members sometimes transfer residents using the EZ-stand with only one staff member. Staff B stated plans to educate staff members regarding the requirement for two staff members when using facility lifts. On 7/22/26 at 1:40 PM Staff D, CNA, confirmed staff members sometimes use the EZ-stand on residents with only one staff member. Staff D confirmed the facility requires two staff members at all times. On 7/22/26 at 3:00 PM the Director of Nursing confirmed facility expectations require staff members to utilize two staff members for EZ-stand or mechanical transfers at all times. On 7/23/26 at 12:44 PM the Administrator and Staff E, RN, confirmed facility expectations require staff members to always utilize two staff members when transferring residents using mechanical lifts and the EZ-stand.		