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	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care Center	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003 Based on clinical record review, policy review and staff interviews, the facility failed to ensure code status between, the Iowa Physician Orders for Scope of Treatment (IPOST), the electronic health record (EHR) and the Care Plan were congruent for 1 of 1 residents reviewed for advanced directives (Resident #3). The facility reported a census of 60 residents. Findings include The Care Plan for Resident #3 with a revised date of [DATE] had a focus area for Advanced Directives with a goal for the Advanced Directives to be Full Code. The Iowa Physician Orders for Scope of Treatment (IPOST) dated [DATE] for Resident #3 indicated the resident desired to be Do Not resuscitate (DNR) status in the event his heart stopped beating and was signed by the resident and physician. A review of the Resident #3's Electronic Health Record (EHR) profile tab and Orders tab documented code status as Full Code (cardiopulmonary resuscitation (CPR) status). During an interview on [DATE] at 10:41 AM Staff A, Registered Nurse (RN) reported she finds code status on the main part of the profile in the EHR. During an interview on [DATE] at 10:45 AM Staff B, Licensed Practical Nurse (LPN) reports he finds code status on the main part of the profile in the EHR under code status. In an interview on [DATE] at 11:47 AM Staff C, LPN/Care Plan Nurse reported staff should look at the IPOST book for code status. She reported Resident #3's status should have been changed in the EHR to match the IPOST. The facility policy titled Resuscitation for SNF and ICF Setting with a revised date of ,d+[DATE] directs staff the code status election from the IPOST shall match the code status designation in the PointClickCare (EHR) Orders tab of the medical record.

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
	165365	A. Building B. Wing	11/07/2024

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48003 Based on clinical record review and staff interview the facility failed to notify the state ombudsman for 1 of 2 residents (Residents #9) reviewed. The facility reported a census of 60 residents. Findings include: Resident #9 Emergency Care (ED) Physician Notes 4/17/24 document the resident arrived at the ED by ambulance at 4:31 PM and was admitted to the hospital after evaluation in the ED. The Progress Note written on 4/22/24 at 3:41 PM for Resident #9 documented the resident readmitted from the hospital. Review of the facility's Ombudsman report for April 2024 lacked documentation of Resident #9 transferring to the hospital on 4/17/24. On 11/06/24 at 09:46 AM the Administrator confirmed Resident #9 should have been on the Ombudsman report.

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	165365	A. Building B. Wing	11/07/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 48003 Based on clinical record review, staff interviews and the Resident Assessment Instrument (RAI) manual, the facility failed to accurately document and submit accurate resident Minimum Data Set (MDS) Assessments for 2 of 15 residents reviewed (Resident #50 and #62). The facility reported a census of 60 residents. Findings include: 1. The MDS for Resident #50 dated 10/06/24 documented a Brief Interview for Mental State (BIMS) score of 8 indicating moderate cognitive impairment. The MDS further documented the resident had a 5 percent or more weight loss in the past month or 10 percent or more in the last six months. Review of Resident #50's weights revealed the weight on 9/29/24 of 137 pounds and weight on 10/08/24 of 169.2 pounds was struck out documenting it was incorrect documentation. Review of the other weights lack documentation of a weight loss. During an interview on 11/05/24 at 1:45 PM the Dietician reported she most likely recorded it on the MDS due to the weights at the time but documented in the notes that she was unsure of weight loss at the time due to possible inaccurate weights. If the weight was inaccurate the MDS should have been modified. She reported after speaking with the nursing staff Resident #50's weights were inaccurate and that is why they were crossed out and she should have modified the MDS. During an interview 11/05/24 at 2:45 PM the Administrator reported the facility had moved the weight stand and so they had issues with weights during that time and staff should have reweighed the resident. 2. The MDS for Resident #62 dated 8/31/24 documented a BIMS score of 14 indicating intact cognition. The MDS further documented the resident discharged to a short-term general hospital. The Progress Note for Resident #62 dated 8/31/24 at 12:45 PM documented the resident being discharged to home with family. During an interview on 11/05/24 at 2:48 PM Staff D, MDS coordinator reported the MDS was coded incorrectly. It should have been coded Resident #62 discharged to home. Record review of the current RAI Manual dated 10/2023 on page 1-4 instructed the assessment accurately reflects the resident's status.

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	165365	A. Building B. Wing	11/07/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50874 Based on observation, record review, family and staff interview the facility failed to assess and follow up on a significant weight loss for 1 of 2 residents (Resident #21) reviewed. The facility reported a census of 60 residents. Findings include: Resident #21 Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5 out of 15 indicating severe cognitive impairment. The MDS documented Resident #21 as needing supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.) with eating. The MDS further documented diagnoses anemia, atrial fibrillation, coronary artery disease, diabetes mellitus and non-Alzheimer's dementia. The Nutrition assessment dated [DATE] revealed Resident #21 received a general diet with cut meat and regular portion sizes. It documented the resident receives supervision at meals in the north dining room and is able to feed himself. A nutrition goal to avoid significant weight changes with diet and interventions in place. The Care Plan initiated on 9/29/2023 identified a focus area for nutritional risk due to diabetes mellitus, fragile skin, dementia and heart disease. The goal in place is to not have a significant weight change in the next 90 days. The Resident Assessment Instrument (RAI) manual states weight loss can result in debility and adversely affect health, safety and quality of life. Weight loss is defined as a 5% or greater weight loss within 30 days. Resident #21 weight records revealed a 12 pound or 6.03% weight loss in a 30-day time frame. The record documented a weight of 199.0 pounds on 10/6/2024 at 10:24 AM for Resident #21. On 11/3/2024 at 1:54 PM the record documented a weight of 187.0 for resident #21. During an interview on 11/5/2024 at 2:12 PM Staff E, Certified Nursing Assistant (CNA) reported Resident #21 eats independently and he does not eat much. Staff E, did not recall how often Resident #21 is weighed. In an interview on 11/6/2024 at 10:36 AM Staff F, CNA reported Resident #21 is able to feed himself and is weighed weekly. Staff F acknowledged if there is a 5 pound difference from the previous weight to the current weight the nurse will instruct the resident to be reweighed. On 11/6/2024 at 12:15 PM Resident #21 was observed in the dining room. The facility provided Resident #21 with a cup of coffee, one 8-ounce glass of orange juice, two 8-ounce glasses of milk, a hot beef sandwich with mashed potatoes with gravy, and peaches. Observed Resident #21's spouse sitting at the table beside him. Following the meal, Resident #21 spouse verbalized Resident #21 consumed his milk and orange juice, and ate only his peaches and meat. Resident #21's spouse stated he has not had a tremendous appetite lately and she had not been notified of any fluctuation in his weight this week. (continued on next page)

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	165365	A. Building B. Wing	11/07/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/2024 at 12:43 PM, Staff A, Registered Nurse (RN) verbalized residents are weighed weekly on Saturdays unless ordered differently by the physician. She reported the nurse reviews the weights for discrepancies and if more then 3 pounds, the resident is reweighed. Staff A, RN verbalized that the physician and family are to be notified when significant weight loss/gain occur. Staff A, RN reported she was unaware of any significant weight loss for Resident #21. On 11/06/2024 at 1:46 PM Staff A, RN recorded a weight of 203.5 pounds for Resident #21. This is an increase of 16.5 pounds or 8.82% in weight gain from the most recent recorded weight. The Electronic Health Record lacked any further documentation. During an interview on 11/6/2024 at 2:28 PM Staff C, Care Plan Nurse/Licensed Practical Nurse (LPN) revealed the Care Coordinators, MDS Coordinator and the consultant dietitian review the 24-hour reports on Monday for significant weight changes. Staff C, LPN verbalized she is unaware of the significant weight loss recorded for Resident #21. A review of the Food/Fluid Intake record for Resident #21 for the past 30 days revealed the following: 10/9/2024 1:03 PM lunch meal - 25% of meal consumed 10/12/2024 evening meal - no record of meal consumed or refused 10/14/2024 6:26 PM evening meal - 10% of meal consumed 10/15/2024 12:50 PM lunch meal - 50% of meal consumed 10/16/2024 12:48 PM lunch meal - 25% of meal consumed 10/19/2024 evening meal - no record of meal consumed or refused 10/20/2024 13:52 PM lunch meal - 0% of meal consumed 10/22/2024 13:47 PM lunch meal - 0% of meal consumed 10/22/2024 7:00 PM evening meal - 0-25% of meal consumed 10/26/2024 1:54 PM lunch meal - 26%-50% of meal consumed 10/26/2024 evening meal - no record of meal consumed or refused 10/27/2024 evening meal - no record of meal consumed or refused 10/30/2024 12:35 PM lunch meal - 0-25% of meal consumed 10/30/2024 evening meal no record of meal consumed or refused 10/31/2024 9:10 breakfast meal - 0-25% of meal consumed (continued on next page)

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	165365	A. Building B. Wing	11/07/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/31/2024 12:53 PM lunch meal - 26%-50% of meal consumed 11/2/2024 1:00 PM lunch meal - 26%-50% of meal consumed 11/4/2024 12:48 PM lunch meal - 0%-25% of meal consumed 11/5/2024 12:15 PM lunch meal -26%-50% of meal consumed 11/5/2024 evening meal - no record of meal consumed or refused The facility Weight Monitoring Policy undated revealed weights will be communicated to the physician and family immediately as significant changes occur. The policy designates the Director of Nursing (DON) or designee in the facility will determine significant weekly and monthly weight changes (5% or greater in 30 days and 10% or greater in 180 days) and communicate this information to pertinent staff. Residents weighed weekly will need to have their 30-day and 180-day weights calculated weekly. For example, week 1 will be compared to week 1 of the subsequent month and that same week 6 months ago. The medical records computer program or spreadsheet may be used to calculate this if completed in a timely manner. Weekly weights are to be reviewed by the DON or designee and Consultant Registered Dietitian to identify weight change trends that need to be acted upon quickly. Residents weighed monthly will be weighed at approximately the same week of each month to ensure weights can be compared with previous 30 day and 180 day periods. A significant unintentional weight change is one of two factors that can trigger the need to complete a full MDS and update the care plan. Weight changes attributed to flu or changes in a diuretic be will be documented to indicate cause and whether this is an acute or chronic problem. The physician and family are both to be notified immediately of any significant unintentional weight changes, whether expected or not. Documentation of this notification must be present in the medical record within 24 hours of documenting the weight change and be kept in the medical record. Notification should include a brief assessment of the resident ' s condition and factors that may be contributing to the weight change, as well as proposed or implemented interventions for MD review. A review of the Nurse Progress Notes revealed the facility lacked assessment of Resident #21 for the significant weight change and failed to notify the physician and failed to notify the family.

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	165365	A. Building B. Wing	11/07/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40907 Based on observation, interviews and record review, the facility failed to ensure the chlorine in their dishwasher was at the correct level for sanitizing dishes. The facility reported a censure of 60 residents. Findings include: On 11/4/24 at 10:20 AM, the dishwasher was tested with a strip. The strip read between 25 Points Per Million (ppm) and 50 ppm. The kitchen staff stated they were going to look into this more. On 11/5/24 at 1:40 PM, the Housekeeping/Laundry Supervisor tested a new dishwasher strip. She stated it was between 50 ppm and 100 ppm. When the surveyor pointed out that the strip read between 25 ppm and 50 ppm, the supervisor concurred that it read between 25 ppm and 50 ppm. On 11/5/24 at 1:45 PM, the facility's Dietitian stated they have a new dishwasher which was probably placed in the last 2-3 weeks. The Dietitian stated that all of the corporation's facilities changed over to new dishwashers. The Dietitian stated she would need to check with their corporation to see what they are doing to ensure the dishes are getting sanitized. On 11/5/24 at 2:49 PM, the Housekeeping/Laundry Supervisor ran the dishwasher again. Observed steam to be coming out of the dishwasher. The temperature gauge revealed a temperature of 134 degrees Fahrenheit (F). She then tested a new strip and it still read between 25 ppm to 50 ppm. She acknowledged that the strip was showing that the chlorine level was not high enough. The Supervisor was using a different strip on this day that was made by the same manufacturer of the dishwasher. On 11/5/24 at 2:53 PM, the Sales Technician for the dishwasher and it's chemicals, stated that the dishwasher is a low temperature dish machine. The Technician stated that the temperature for the dishwasher should be between 120 degrees Fahrenheit (F) and 150 degrees F. He stated that the temperature of the dishwasher should go no higher than 150 degrees F because it would burn the sanitizer. The Sales Technician stated he did not install the dishwasher at this facility. He stated that maybe the guys that did install the dishwasher ran it a few times and then left. He stated maybe the water is getting too hot and if so, it could burn off the sanitizer, he stated this was just speculation. He stated that there was a sticker right on the top panel of the dishwasher with what parts per million the chemical strips should read. He stated the parts per million (ppm) should be at least 50. The Sales Technician stated they could turn the dishwasher up to be sure it reaches at least 50 ppm. He stated someone would come to the facility in 2 days to adjust the dishwasher. When told the facility stated they were using the wrong chemical strip, this technician said that wouldn't matter, either strip could be used. The Sales Technician called back and stated that they would send a technician out to the facility on this night. The sticker on top of the dishwasher reads required 50 ppm available chlorine rinse. (continued on next page)

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	165365	A. Building B. Wing	11/07/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/06/24 at 10:46 AM, the corporate dietitian stated that the kitchen staff were using the wrong strips and now they have the right strips. This Dietitian tested the dishwasher and the strip read between 50 ppm and 100 ppm. When told the technician stated that it didn't make a difference what strip was used, this dietitian acknowledged this. The dietitian acknowledged that the strips ran yesterday were the strips that should be used. A Service Manual dated 5/2008; for the facility dishwasher directed: Sanitizer should be 6% solution of sodium hypochlorite. The initial setting is 5cc (cubic centimeters) and this should be checked regularly with a Chlorine Test Kit. Free chlorine in the final rinse should be 50 ppm or more. However, high concentrations can cause deterioration of metal.

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	165365	A. Building B. Wing	11/07/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48003 Based on observations, staff interviews and the Assure Prism Manual, the facility failed to perform proper hand hygiene, appropriately sanitize the blood sugar meter and use barrier when doing blood sugar checks and insulin for 2 of 2 residents reviewed (Resident #21 and #53). The facility reported a census of 60. Findings include: 1. The Minimum Data Set (MDS) for Resident #21 dated 9/06/24 documented a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment. The MDS documented Resident #21 has a diagnosis of diabetes and received insulin injections. During an observation on 11/05/24 at 7:52AM, Staff B, Licensed Practical Nurse (LPN) reported he was checking Resident #21's blood sugar. Staff B had already gathered the Assure Prism blood sugar meter (a device for measuring the concentration of glucose in the blood, typically using a small drop of blood placed on a disposable test strip) and supplies in a basket and went into his room. Staff B set supplies down on the bed, applied gloves, and cleansed Resident #21's finger with alcohol and poked the finger with the lancet. Staff B picked up the meter and got the blood on the test strip. The resident's blood sugar was 252. Staff B then took out the test strip and placed the blood sugar meter in the basket. After Staff B performed the blood sugar check, then returned to the medication cart. Staff B then placed the blood sugar meter in the basket back in the cart without cleaning the meter or the outside of the plastic basket. Staff B then looked up what amount of Novolog to give to the resident. Staff B then gathered the Novolog pen and alcohol, wiped the tip and applied a needle cap. Staff B then measured up 26 units of Novolog and went into the residents room. He then cleansed the right lower quadrant on Resident #21's abdomen and gave the Novolog injection without applying gloves. Staff B left the room, took the secure needle cap off and put it in the sharps container. Staff B went on the computer and signed out the medications. He then started to gather for the next resident he was going to pass medication for without doing any post hand hygiene from working with Resident #21. During an interview on 11/06/24 at 11:18 AM, Staff A, Registered Nurse (RN) reported staff are to clean the blood sugar machines between each resident. She reported the staff use Sani-cloth (it is a brand of germicidal wipes). During an interview on 11/06/24 11:25 AM Staff B, LPN reported Sani-cloth wipes are to be used to clean the blood sugar meter between residents. He reported he also should wear gloves when giving insulin. He further reported hand hygiene should be done between residents, with glove changes and if his hands get soiled. In an interview on 11/07/24 at 7:25 AM the Director of Nursing reported staff are to use Sani-cloths to clean the blood sugar meter between residents and a barrier should be under supplies. Staff are to wear gloves when giving insulin and should be doing proper hand hygiene before, with gloves changes and after working with residents for care. (continued on next page)

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	165365	A. Building B. Wing	11/07/2024

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS for Resident #53 dated 7/29/24 documented she has severely impaired cognitive skills and memory problems. The MDS documented Resident #53 has a diagnosis of diabetes and received insulin injections. During an observation on 11/05/24 at 7:52AM, Staff B, Licensed Practical Nurse (LPN) reported he was checking Resident #21's blood sugar. Staff B had already gathered the blood sugar meter and supplies in a basket and went into his room. Staff B set supplies down on the bed, applied gloves, and cleansed Resident #21's finger with alcohol and poked the finger with the lancet. Staff B picked up the meter and got the blood on the test strip. The resident's blood sugar was 252. Staff B then took out the test strip and placed the blood sugar meter in the basket. Staff B returned to the medication cart, and placed the blood sugar meter in the basket back in the cart without cleaning the meter or the outside of the plastic basket. Staff B then looked up what amount of Novolog to give to the resident. Staff B then gathered the Novolog pen and alcohol, wiped the tip and applied a needle cap. Staff B then measured up 26 units of Novolog and went into the residents room. He cleansed the right lower quadrant on Resident #21's abdomen and gave Novolog injection without applying gloves. Staff B left the room and took the secure needle cap off and put it in the sharps container. Staff B then went on the computer and signed out the medications. He then started to gather for the next resident he was going to pass medication for without doing any post hand hygiene from working with Resident #21. On 11/05/24 at 8:05 AM observed Staff B, LPN gather supplies and get the medications ready for Resident #53. Staff B reported he was going to check Resident #53's blood sugar and she will get 18 units of Lantus which he also gathered the supplies with the medications. Staff B set the glucometer in the basket with the insulin down on the nightstand with no barrier under the basket. Staff B gave Resident #53's the medications crushed in applesauce and went to the sink in the room to wash his hands. Staff B put soap on his hands and washed for 20 seconds and rinsed the soap off. Staff B then with his right hand shut the sink off with his clean hand. Staff B noticed no paper towels in the room so he grabbed a wash cloth hanging on the towel rack by the sink and dried his hands with the wash cloth then hung the wash cloth back up. Staff B then applied gloves and checked the blood sugar on Resident #53. The blood sugar was 225. Staff B then gave Lantus (long acting insulin) after alcohol swabbing the area. Staff B removed his gloves and went out of the room taking the Lantus pen and basket with the blood sugar meter. Staff B put the basket with the meter in the cart without sanitizing either. Staff B removed the secured needle cap and put it in the sharps container and placed the lid on the insulin pen and put it back in the plastic bag with the pharmacy label in the med cart. Staff B gathered Novolog sliding scale 4 units for the resident after comparing it with the Medication Administration Record. Staff B then went back into the room and applied gloves and used an alcohol wipe to cleanse the area. Staff B gave the Novolog and then removed his gloves and left the room. Staff B then threw the gloves in the garbage, took the secure needle cap off the insulin and put it in the sharps container. Staff B recapped the Novolog and placed it back in a plastic pharmacy labeled bag and put it in the medication cart. Staff B then signed off on the medications on the computers without completing hand hygiene. Staff B then proceeded with the med cart down the hallway to the next room. The undated Assure Prism Glucose Manufacturer's Quality Assurance/ Quality Control Reference Manual for use documented the following: Before performing a blood glucose test, observe the following safety precautions: (continued on next page)

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	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All components that come into contact with blood samples should be considered to be biohazards capable of transmitting viral diseases between patients and healthcare professionals. Before testing each patient, a new pair of clean gloves should be worn by the user. Wash hands thoroughly with soap and water before putting on a new pair of gloves and performing the next patient test. Use only an auto-disabling, single-use lancing device for each patient. After use on each patient, the meter should be cleaned and disinfected. CLEANING AND DISINFECTING THE METER: To minimize the risk of transmitting blood-borne pathogens, the cleaning and disinfection procedure should be performed as recommended in the instructions below. The meter should be cleaned and disinfected after use on each patient. The Assure Prism multi Blood Glucose Monitoring System may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed. Cleaning and Disinfection The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfection procedure. The disinfection procedure is needed to prevent the transmission of blood-borne pathogens. A variety of the most commonly used EPA-registered wipes have been tested and approved for cleaning and disinfecting of the Assure Prism multi Blood Glucose Monitoring System. Cleaning : Step 1: Wear appropriate protective gear such as disposable gloves. Step 2: Open the towelette container and pull out 1 towelette and close the lid. Step 3: Wipe the entire surface of the meter 3 times horizontally and 3 times vertically using 1 towelette to clean blood and other body fluids. Step 4: Dispose of the used towelette in a trash bin. Disinfecting (The meter should be cleaned prior to disinfection.): Step 5: Open the towelette container and pull out 1 towelette and close the lid. Step 6: Wipe the entire surface of the meter 3 times horizontally and 3 times vertically to remove blood-borne pathogens. Step 7: Dispose of the used towelette in a trash bin. Step 8: Allow exteriors to remain wet for the appropriate contact time and then wipe the meter using a dry cloth. Step 9: After disinfection, the user's gloves should be removed and thrown away. Wash hands before proceeding to the next patient. The CDC has become increasingly concerned about the risks for transmitting hepatitis B virus (HBV- a serious liver infection) and other infectious diseases during assisted blood glucose (blood sugar) monitoring and insulin administration. The CDC is alerting all persons who assist others with blood glucose monitoring and/or insulin (continued on next page)

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	11/07/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration of the following infection control requirements: a. Fingerstick devices should never be used for more than one person b. Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. Unsafe practices during assisted monitoring of blood glucose and insulin administration that have contributed to transmission of HBV or have put persons at risk for infection include: a. Using a blood glucose meter for more than one person without cleaning and disinfecting it in between uses. Blood glucose meters are devices that measure blood glucose levels. a. Whenever possible, blood glucose meters should be assigned to an individual person and not be shared. b. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared.