

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Red Oak Rehab and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 Summit Street Red Oak, IA 51566	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48004</p> <p>Based on clinical document review, staff interview, and policy review the facility failed to provide a comprehensive care plan related to high risk medications for residents with an order for anticoagulants for 1 of 5 residents (Residents #10) reviewed. The facility reported a census of 25 residents.</p> <p>Findings include:</p> <p>Review of Resident #10's Minimum Data Set (MDS) dated [DATE] revealed anticoagulant medication usage for 7 of the 7 day look back period.</p> <p>Review of Resident #10's Electronic Healthcare Record page titled Physician's Orders revealed an order for Apixaban 5mg oral tablet take 1 tablet by mouth twice daily.</p> <p>Review of Resident #10's Care Plan with a review date of 8/23/24 revealed no documentation of anticoagulant medications.</p> <p>Interview on 10/22/24 at 2:48 PM with Staff D, MDS coordinator, confirmed Resident #10 is on an anticoagulant. Staff D further revealed that anticoagulants should be on care plans.</p> <p>Interview on 10/22/24 at 3:03 PM with the Director of Nursing (DON) revealed that her expectation is for care plans to be complete and accurate.</p> <p>Review of a facility provided policy titled, Care Planning with a revision date of March 2019 revealed:</p> <p>a. Physician's orders are referenced in the resident's care plan.</p>

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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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>48004</p> <p>Based on document review, staff interview and facility policy review the facility failed to ensure a Registered Nurse (RN) was in the facility for eight (8) consecutive hours for 11 of 90 days reviewed (April 1st through June 30th 2024). The facility reported a census of 25 residents.</p> <p>Findings include:</p> <p>Review of the Payroll Based Journal (PBJ) staffing data report for the fiscal year quarter three (April 1st through June 30th, 2024) revealed there was no Registered Nurse (RN) hours for 4/29, 5/4, 5/18, 5/23, 5/31, 6/1, 6/2, 6/11, 6/15, 6/16, and 6/25/2024.</p> <p>Interview 10/22/24 at 12:52 PM with the Administrator confirmed that the facility did not have RN coverage listed on the PBJ. The Administrator confirmed these dates, and revealed that the facility only had one RN at the facility during this time. The Administrator revealed that her expectation would be for 8 hours RN coverage per day.</p> <p>Review of a facility provided document titled, Facility Assessment with a completed date of 7/15/2024 revealed:</p> <p>a. Federal law requires nursing homes to have sufficient staff to meet the needs of residents, to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47079</p> <p>Based on observation, staff interview, and policy review, the facility failed to maintain sanitary practices by improperly serving food and failing to ensure proper sanitizing solution concentration. The facility reported a census of 25 residents.</p> <p>Findings include:</p> <p>On 10/23/24 at 9:36 AM, Staff A, [NAME] and Staff B, Dietary Aide (DA) were unable to locate sanitizer test strips to perform a sanitizing solution concentration check. Staff B stated she used detergent to clean the dining room tables.</p> <p>On 10/23/24 observations in the kitchen revealed the following:</p> <p>At 11:45 AM, Staff A, Cook, grabbed potato chips from a bag and placed them on a resident's plate with gloved hands she previously used to touch other non-food items.</p> <p>At 11:55 AM, Staff A placed the mashed potato serving scoop in the mashed potatoes and the handle came in direct contact with the food. She picked it up and continued using it with the same gloves she had touched non-food items.</p> <p>At 12:00 PM, Staff A scooped meatloaf sauce into a bowl and used her right gloved hand to push the sauce off the rim and into the bowl and served it to a resident. She previously used the gloves to touch non-food items.</p> <p>At 12:04 PM, Staff C, Dietary Manager (DM), used her gloved hands to move menus and a tray from the serving window. She grabbed a plate with the same gloved hand and her thumb touched the food contact surface.</p> <p>At 12:05 PM, Staff A prepared fruit cocktail bowls for residents with gloved hands. She walked over to the service counter and stuck her gloved hand into the loaf of bread and grabbed two (2) slices. She put them on the resident's plate and spread peanut butter on one slice. She grabbed the jelly container and squeezed jelly onto the slice of bread. She picked up the slice of bread with the same left gloved hand and continued making the resident's sandwich. No hand hygiene or glove change was performed.</p> <p>On 10/24/24 at 8:34 AM, the DM stated staff should perform appropriate hand hygiene and the sanitizing solution strips should be accessible and used correctly.</p> <p>A policy titled Handwashing Guidelines for Dietary Employees and dated 2023 directed staff to clean their hands while preparing food, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks.</p>		