Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Manor	737 North Highway Oakland, IA 51560

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 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** 41785 Based on clinical record review, family interviews, resident interview, staff interviews and facility policy review the facility failed to notify resident representatives after falls for 2 of 3 residents (Resident #6, and #4) reviewed. The facility reported a census of 48 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #6 had a Brief Interview for Mental Status (BIMS) of 11 (moderate cognitive deficits). The resident required set-up assistance with hygiene, dressing needs, and supervision for walking and toileting. The resident's diagnoses included coronary artery disease, non- Alzheimer's dementia, encephalopathy, and alcohol dependence with persisting amnestic disorder. The Care Plan updated on 3/18/24, showed that Resident #6 had limited physical mobility related to alcohol abuse and dementia, and the discharge plan was to go home. Staff directed to evaluate and record the resident's abilities. The resident admitted for a short term stay and required therapy services for strengthening and pain management. According to the incident report, on 3/12/24 at 7:45 PM, Resident #6 pushed another resident in a wheelchair outside. While pushing the wheelchair, he stepped off sidewalk onto grass, lost footing and fell on to the ground. Staff completed an assessment and found no injuries at the time of incident. The Director of Nursing (DON), and Assistant Director of Nursing (ADON) notified the physician. The document lacked information regarding family notification. On 4/16/24 at 8:11 AM, a family member for the resident said that she did not have any knowledge of a fall on 3/12/24. 2) According to the MDS dated [DATE], Resident #4 admitted to the facility on [DATE] and had a BIMS score of 15 (intact cognitive ability). The resident used a walker for mobility and required substantial assistance with toileting, dressing and personal hygiene. The MDS documented the resident frequently incontinent of bladder and always incontinent of bowel. Her diagnoses included deep venous thrombosis, renal insufficiency, seizure disorder, anxiety and depression. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan updated on 3/5/24, showed that Resident #4 was at risk for falls, and staff directed to initiate frequent neurological assessments and bleeding evaluation if/when she would fall. The resident had a history of pain, staff to monitor and report resident complaints of pain. The Progress Note dated 3/27/24 at 12:25 PM, showed that Resident #4 reported to staff that when she stood up to go to the bathroom, she got dizzy, fell and hit her head. On 4/17/24 at 8:22 AM, the emergency contact and representative for Resident #4 said that she was not aware that the resident had a fall on 3/27/24. She said that initially, the facility would call her about everything but that seemed to change. On 4/17/24 at 8:52 AM, the DON and ADON said that on 3/27/24, the resident discharged and her representative was on her way, so they figured she must've been told about the fall at that time. They acknowledged that the chart lacked a neurological assessment or a full body assessment after the unwitnessed fall. The DON said that it is expected that nursing would do a full assessment for an unwitnessed fall. On 4/17/24 at 10:20 AM Resident #4 said that when she was discharged home, she had another fall and ended up right in the hospital again. She said that there was a lot of miscommunication at the facility. According to a facility policy title: Notification of a Change in Condition, dated 4/27/23, the attending physician and the resident representative would be notified of a change in residents' condition per stands of practice and federal and or state regulations. Guidelines for notification of physician/resident representative include accident/incidents.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview and record review the facility failed to provide accurate and timely assessment and interventions. Staff failed to obtain a physician's order for home medications for 1 of 3 residents reviewed (Resident #3). Staff failed to adequately assess 1 of 3 residents reviewed for falls (Resident #4), and failed to contact the physician with high blood glucose levels for 2 of 2 residents reviewed (Resident #2, #9). The facility reported a census of 48 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #3 had a BIMS score of 15 (intact cognitive ability). He needed some help with self-care and used a manual wheelchair. Resident #3 required partial assistance with dressing, and toileting. He had an external urinary catheter and was always incontinent of bowel. Diagnosis included anemia, obstructive uropathy, diabetes mellitus, malnutrition and schizophrenia. The care plan showed that Resident #3 had been approved for short-term nursing home placement. Discharge planning included in-home meals, and the Social Worker would assist to set up grocery delivery upon discharge. Staff were to plan the discharge with the resident and family members and evaluate progress. Resident #3 had diabetes mellitus, a history of falls and hypotension (low blood pressure). He was incontinent of bowel and had chronic diarrhea. The resident was admitted to facility therapy services for strength endurance or pain management. On 4/16/24 at 11:58 AM Staff A, Licensed Practical Nurse (LPN) said that she did not get advanced notice that Resident #3 would be discharged during her shift on 4/9/24. Shortly after she started her shift, Staff A learned that a driver was ready to take the resident to his apartment with the facility van. She didn't know how to do a discharge and the medication list hadn't been sent to the pharmacy. Staff A said that the Administrator told her to gather left over medications and send them with the resident. Staff A was not sure about giving the resident narcotics, but she was told that it was alright. Resident #3 had 3 tabs of hydrocodone-acetaminophen (hydro/APAP) 5-325 milligrams (mg) in the drawer. She said he had his evening dose of meds and understood that the pharmacy would have what he needed the next day and home health would be in. According to the Controlled Substance Accountability Sheet, on 4/9/24 at 12:45 PM, 3 tabs of Hydroco/APAP 5-325 mg had been given to resident. On 4/17/24 at 11:27 AM, the Administrator said that Alixa was a medication service they use to dispense daily medications. Alixa also provided a service that would send supplies of medications for residents upon discharge. When a resident was discharged , they could ship the supply overnight. She said that typically, they would need a 72-hour timeframe to get the medications to the facility. The Administrator said she had the application completed for home medication for Resident #3 and had given it to the nursing staff. She said that nursing did not follow up on the order. On 4/18/24 at 8:00 AM, the Assistant Director of Nursing (ADON) pointed out a standing order dated 4/3/24 that said: okay to discharge with current medication and treatment with home health of choice if needed. Authorized by the Nurse Practitioner (NP). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/18/24 at 8:44 AM, the NP said that the general discharge order was entered by nursing and not intended to include authorization to send medications home. She said that if/when they send medications home with a resident it would be a separate, more detailed order to include what medications and number of days, usually just enough to get them through to their first doctor appointment. When asked if she was aware that Resident #3 had been discharged with medications from the facility that included narcotics, the NP said that she was not aware of that and said I would never authorize that She added that a narcotics order would require a separate prescription. According to a facility policy titled: Discharge with Medications; may be sent with the resident on discharge if ordered by the prescriber. The prescriber should list the medications to be released upon discharge. 2) According to the MDS dated [DATE], Resident #4 was admitted to the facility on [DATE] and had a BIMS score of 15 (intact cognitive ability). The resident used a walker for mobility and required substantial assistance with toileting, dressing and personal hygiene. The resident was frequently incontinent of bladder and always incontinent of bowel. Her diagnosis included; deep venous thrombosis, renal insufficiency, seizure disorder, anxiety and depression. The care plan updated on 3/5/24, showed that Resident #4 was at risk for falls, and staff were directed to initiate frequent neurological assessments and bleeding evaluation if/when she would fall. The resident had a history of pain, staff were to monitor and report resident complaints of pain. Resident #4 had a psychosocial well-being problem related to anxiety. A nursing note dated 3/27/24 at 12:25 PM, showed that Resident #4 reported to staff that when she stood up to go to the bathroom, she got dizzy, fell and hit her head. The chart lacked a complete assessment to include neurological checks. On 4/17/24 at 8:52 AM, The Director of Nursing (DON) and Assistant Director of Nursing (ADON) acknowledged that the chart lacked an incident report for fall on 3/27. not a neuro assessment in the chart or documentation of a full body assessment after the unwitnessed fall. The DON said that it is expected that nursing would do a full assessment to include neuros for an unwitnessed fall. On 4/17/24 at 10:20 AM, Resident #4 said that when she was discharged home, she had a fall and ended up back in the hospital. She said that when she fell in the bathroom at the facility, staff did not check her head or anywhere on body for injuries. Policy titled Neurological Evaluation dated 3/28/23, a neurological evaluation would be performed by a license nurse when the resident status warrants; suspected head injury or unwitnessed fall to identify a change in condition related to possible head injury. 3) The MDS dated [DATE] for Resident #9 showed that she was admitted to the facility on [DATE] Resident #9 had a BIMS score of 15 (intact cognitive ability). She required set-up assistance for eating, dressing and hygiene, and supervision only for transfers and toileting. Her diagnosis included heart failure, renal insufficiency, diabetes mellitus, metabolic encephalopathy, and thyroid disorder. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan last updated on 2/28/24, showed a self-care performance deficit related to congestive heart failure. Resident #9 had a history of severe sepsis related to diabetes mellitus and impaired cognitive function related to dementia. Staff were directed to educate the resident regarding medications and importance of compliance and to monitor for side effects and effectiveness of diabetes medications. In an observation on 4/18/24 at 11:54 AM, Resident #9 was still in bed. At 12:40 PM, Staff set a covered plate and 2 drinks on her nightstand. The resident was sleeping in bed and did not respond to a knock on the door. At 1:05 PM, she was in the same position and the food had not changed with the lid still on top of the plate, at 1:29 PM, she was in the same position and the lid was still on the plate. At 2:20 PM Resident #9 was sitting on the side of her bed eating the food that was left for her earlier. When asked if the staff had taken her blood glucose she said they do that before every meal. According to the Medication Administration Record (MAR), Resident #9 had an order dated 7/10/23 at 11:09 AM, for blood sugar readings to be taken at 8:00 AM, 12:00 PM, and 4:30 PM, before meals. The orders tab in the electronic chart showed an order dated 3/29/24 to notify the physician if the blood sugar was less than 70 or greater than 200. According to the Blood Sugar Summary in the electronic chart, in the month of April, on the following days Resident #9 had blood sugar levels outside of parameters; over 400 milligrams per deciliter (mg/dl), under 70 mg/dl, and the nursing notes lacked documentation that the physician had been notified. 4/21/24 at 1:16 PM; 499 4/20/24 at 5:17 PM; 450 4/16/24 at 10:14 PM; 409 4/16/24 at 7:48 AM; 55 4/15/24 at 4:29 PM; 54 4/13/24 at 1:00 PM; 46 4/11/24 at 5:20 PM; 442 4/8/24 at 8:51 AM; 475 4/3/24 at 1:21 PM; 418 4/2/24 at 6:01 PM; 415 4/2/24 at 7:52 AM; 573 4/1/24 at 9:00 AM; 61 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the chart revealed that the most recent progress note for Resident #9 was on 3/28/24 at 5:40 PM. 4) The MDS dated [DATE], showed that Resident #2 had a BIMS score of 15 (intact cognitive ability). The resident required substantial assistance with toileting, showers and dressing. Her diagnosis included anemia, diabetes mellitus, thyroid disorder, hemiplegia or hemiparesis, depression and adult failure to thrive. The care plan updated on 2/28/24 showed that Resident #2 had limited physical mobility related to a stroke that affected the left side and she had impaired cognitive function related to dementia. The resident had diabetes mellitus, staff were directed to administer medications as ordered and to monitor and document for effectiveness. According to the Blood Sugar Summary, in the month of April, the levels for Resident #2 were higher than 400 mg/dl and lower than 70 mg/dl on the following days, and the nursing notes did not reflect communication with the provider or follow up orders: 4/16/24 at 7:48 AM; 45 4/15/24 at 7:15 AM; 55 4/14/24 at 8:00 AM; 57 4/10/24 at 9:50 AM; 55 4/9/24 at 1:34 PM; 400 4/9/24 at 8:45 AM; 65 4/7/24 at 7:50 AM; 493 4/3/24 at 7:30 AM; 62 4/1/24 at 9:16 PM; 439 On 4/22/24 at 12:15 PM, the DON said that the order for physician notification when the blood glucose is over 200 mg/dl, seemed like it was a low number and thought it maybe a mis-entry. Later, she was made aware that the blood sugar parameters per facility policy are; 70 mg/dl and 200 mg/dl. On 4/18/24 at 8:44, the Nurse Practitioner (NP) expressed that the communication between the facility and the providers was inconsistent and she was working with the staff to provide education. She said that she eventually gets information from nursing about concerns, however, it's not always done in a timely manner so that she can follow up with appropriate orders. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy titled: Notification of a Change in Condition indicated that the attending physician and the resident representative would be notified of a change in a Resident's condition, per standards of practice and federal and/or state regulations. Procedures guidelines for notification included glucometer reading below 70 mg/dl or above 200 mg/dl (unless specific parameters were given by the physician for reporting)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on clinical record review, family interview, pharmacy staff interview, home health staff interview, facility staff interviews and facility policy review, the facility failed to ensure adequate discharge planning for 4 of 5 residents reviewed. Facility staff discharged Resident's #1, #3 and #6 without ensuring that they had the needed home medications. Staff discharged Resident #4 without advanced planning or arranging for the needed home health and therapy services. The facility reported a census of 48 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability). The MDS documented the resident independent with all cares and mobility. His diagnoses included seizure disorder, chronic obstructive pulmonary disease, early onset ataxia, alcohol dependence and adult failure to thrive. The MDS documented active discharge planning already occurring for the resident to return to the community and a referral made to the local contact agency. The Care Plan updated on 11/7/23 showed that Residents #1 planned to remain in long term care placement at this center. Staff directed to invite resident and or responsible party to care plan meetings as indicated and review discharge plans quarterly and per resident/responsible party requests. Social service staff to assist with discharge planning. An addition made to the Care Plan on 4/4/24 to establish a pre-discharge plan with resident and family and evaluate progress and revise the plan as indicated. The resident had alteration in his gastro-intestinal status related to polyp removal. He had depression and severe alcohol dependence and nutritional problems related to alcoholism. The Progress Notes for the resident documented the following: On 3/28/24 at 12:28 PM new order to discharge home with current medications and treatments and home health of choice if needed. On 4/8/24 at 7:23 PM resident picked up by a family member at 7:20 PM, resident denies having any questions or concerns with going to independent living situation. Bedtime medication given before leaving. Late entry on 4/9/24 at 11:49 AM per daughters request medication orders faxed to pharmacy of choice. Late entry on 4/9/24 at 6:13 PM daughter called and stated the pharmacy did get the orders but they were unsure on the provider signature due to it not being on the signature line and they could not read it and other concern was the quantity. Nurse got it straightened out to where they knew the provider and quantity. They were also having issues with insurance so nurse got ahold of the Business Office Manager and provided that information. The Progress Notes lack any other documentation on discharge planning. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Discharge Planning Review dated 3/25/24 documented the resident would be discharging to an apartment and his daughter would be the caregiver. The form lacked any documentation on medication or appointment follow up. According to the signed Discharge Summary for Resident #1, initiated and dated 3/31/24 at 4:00 PM, the reason for discharge stated no longer needed skilled level of care. The form documented the treatment provided as PT/OT (physical therapy/occupation therapy) and the progress as returned to baseline. The form documented the resident would be living with his nephew. It also documented the resident refused home health services. The form documented medication list sent with the resident and disposition of medications showed the medications were sent with the resident. The document lacked information regarding scheduled appointments. On 4/15/24 at 11:56 AM, a family member said that when Resident #1 discharged , there was some miscommunication between the facility and the pharmacy, and it took more than a day to get his medications. The family said that she got a call from business personnel on 4/8/24 that the residents authorization for services had run out and if he chose to stay, it would be private pay. The family told her that she did not have the money for the daily rate and the business personnel responded that she could come and pick him up that evening. The family was shocked and unprepared, but couldn't afford to pay for the room so her husband went to the facility that evening. When he got to the facility, the resident was packing up his things by himself. The nurse told him that his medications would be ready for them at the pharmacy. She said that Resident #1 went almost 2 days without his medications and he was having headaches and vomiting, she thought it may have been from not having his Eliquis. While preparing for the discharge, the facility told her that the resident would get meals delivered to his apartment and the business personnel told her not to worry, that they would get everything set up for him. She was told that a home health worker would pick him up from the facility upon discharge, and that the medications would be delivered to his apartment. The family ended up having to take the resident into her home for a week to make sure everything was in line before letting him out on his own. On 4/16/24 at 10:00 AM, the DON said that she had helped with some of the discharges and the form that they sent to the pharmacy was an order summary that did not include quantity. She said that when planning discharges, they try to make sure all the appointments and medications were in place 1-2 days in advance. The DON said that she was not aware that Resident #1 was being discharged on [DATE] and that the resident's daughter just unexpectedly came to pick him up that evening. When asked why, the DON said that it had something to do with his apartment and that he had to be there or he would lose the space. The DON printed off an order summary and sent it to the Nurse Practitioner (NP) to sign electronically. They eventually got it figured out and the resident got his medications on 4/9/24. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/16/24 at 11:58 AM, Staff A, Registered Nurse (RN) said that she was the nurse on duty when Resident #1 was discharged . Just as she had gotten to work, she was told by the business personnel the resident would be leaving in an hour. Staff A said she asked the business personnel about the paperwork and medications, she said she did not know about that, and she left for the day. Staff A sent a text to the DON and Administrator that she hadn't done discharges before. The Administrator told her that the medication list had been faxed over to the pharmacy. When the family member came to get the resident, she gave him the summary and told him that the medications were ready at the pharmacy, but she didn't know which ones or the quantity. Later that evening, the daughter called and Staff A told her she would have to call the next morning to talk to the DON or Administrator with questions. A communication with the pharmacy on 4/18/24 at 1:21 PM, indicated that they received the discharge order summary report for Resident #1 on 4/9/24 at 3:43 PM. The summary did not include a quantity of medication to dispense, the prescriber name was illegible, and there was no phone number or address to contact the facility. The patient representative arrived on 4/9/24 at 6:30 PM to pick up the medications. They were able to get ahold of the Director of Nursing (DON) and eventually were able to get questions answered. The medications were released to family around 7:50 PM on 4/9/24. 2) According to the MDS dated [DATE], Resident #3 admitted to the facility on [DATE] under a Medicare Part A stay. The MDS documented the resident had a BIMS score of 15 (intact cognitive ability). The MDS documented he needed some help with self-care and used a manual wheelchair. The resident required partial assistance with dressing, and toileting, had an external urinary catheter and was always incontinent of bowel. Diagnoses included anemia, obstructive uropathy, diabetes mellitus, malnutrition and schizophrenia. The MDS documented active discharge planning occurring for the resident to return to the community and a referral made to the local contact agency. The Care Plan dated 3/14/24, showed that Resident #3 admitted to facility for a short term stay and required therapy services for strength endurance and pain management. The discharge plan for Resident #3 was to return home with home delivered meals and the Social Worker would assist to set up grocery delivery. Staff directed to establish a pre-discharge plan with the resident and family members and evaluate the progress. Resident #3 had diabetes mellitus, a history of falls with hypotension, bowel incontinence and chronic diarrhea. The Progress Notes for the resident documented the following: On 4/7/24 at 12:16 AM eInteract SBAR completed for nausea and vomiting. Blood glucose at 7:20 AM 92. Diagnoses listed to include diabetes mellitus, adult failure to thrive, noncompliance with medication regime, bipolar disorder and schizophrenia. On 4/7/24 at 12:35 PM blood sugar 453, resident refused noon insulin. On 4/9/24 at 12:25 PM medication set up with Alixa to get him started until he get to the doctor. Meds should go to his home. If they go to the facility to let the Director of Nursing (DON) know so we can get them to him. On 4/9/24 at 1:11 PM resident discharged to his own apartment at approximately 1:00 PM. No complaints of pain prior to leaving and Foley empty. All blood sugar supplies and meter given to resident along with Medication (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administration Record and Treatment Administration Records to give his home heath aide to help set up his meds. All stock medications given to resident and taken by company van. On 4/9/24 at 5:19 PM resident called and said he needed the strips to test his blood sugar that the facility sent everything but that. Nurse took them to him and while nurse there explained again about discharge summary, his appointment on Monday and where it was. Explained what paper work needs taken to the doctor and to ask the doctor to set up his medication with local pharmacy for delivery. Resident stated he did not need anything else before nurse left. On 4/10/24 at 11:46 AM follow up call to resident. Let him know he would need to arrange on transportation to doctor appointments and let him know where they were. He said he was okay. Informed that when his medications came in from Alixa would drop them off. Late entry for 4/11/24 at 10:31 AM call received that resident's blood sugar read high and he did not have medication. Facility searched and did find one each of short acting and long acting insulin. Pharmacy called and they stated his meds were ready but he needed to pay copays. Facility delivered insulin to resident home and local emergency squad there. Insulin given to resident and he stated he didn't want it. Offered to pick up medications but he would need to pay copays and he refused. On 4/12/24 at 11:31 AM nurse called to check on resident and he stated he is doing okay but needs food. He stated he cannot make it to the store, cannot make it up the hill to the store. He stated he was at the hospital yesterday and they sent him home with supplies and the pharmacy and copay all taken care of. The signed Discharge Instructions dated 4/9/24 at 12:45 PM, indicated that Resident #3 would be discharged to his apartment with home health services. The Discharge Summary dated 4/9/24 documented the reason for discharge as improvement back to baseline and end of skilled stay. The summary documented to see drug list and medication scripts sent to Alixa Home Meds. The summary lacked any documentation of meal delivery or grocery delivery as stated above on care plan. On 4/15/24 at 11:56 AM, the home health nurse said that when she went to visit Resident #3 after his discharge from the facility, in his apartment, he did not have enough insulin for his next dose. He was discharged on [DATE] and she visited him on 4/10/24. She said that the facility didn't send medical records with him, and didn't tell him where to go for his medications. The nurse said that she called the pharmacy service that the facility said they used, and they told her they didn't have the proper paperwork so they didn't have medications ready for him. She arranged for Resident #3 to get to the doctor and made sure that he had the needed medication. At that time, the residents blood glucose had been so high that it didn't register on the glucometer so he was sent to the emergency room for stabilization. The nurse said that she talked to the DON on 4/14/24 and she said that they found more insulin pens in the refrigerator for him at the facility, but she had already gotten a supply for him. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024
NAME OF PROVIDER OR SUPPLIER Oakland Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 737 North Highway Oakland, IA 51560	

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/16/24 at 11:58 AM Staff A, Licensed Practical Nurse (LPN) said that she did not get advanced notice that Resident #3 would be discharged during her shift on 4/9/24. Shortly after she started her shift, Staff A learned that a driver was ready to take the resident to his apartment with the facility van. She didn't know how to do a discharge and the medication list hadn't been sent to the pharmacy. Staff A said that the Administrator told her to gather left over medications and send them with the resident. Staff A was not sure about giving the resident narcotics, but she was told that it was alright. Resident #3 had 3 tabs of Hydrocodone-acetaminophen (hydro/APAP) 5-325 milligrams (mg) in the drawer. She said he had his evening dose of meds and understood that the pharmacy would have what he needed the next day and home health would be in. On 4/17/24 at 11:27 AM, the Administrator said that Alixa was a medication service they use to dispense daily medications. Alixa also provided a service that would send supplies of medications for residents upon discharge. When a resident was discharged , they could ship the supply overnight. She said typically, they would need a 72-hour timeframe to get the medications to the facility. The Administrator said she had the application completed for home medication for Resident #3 and had given it to the nursing staff. She said that nursing did not follow up on the order. 3) According to the Minimum Data Set (MDS) dated [DATE], Resident #6 had a Brief Interview for Mental Status. BIMS of 11 (moderate cognitive deficits). The resident required set-up assistance with hygiene, dressing needs, and supervision for walking and toileting. The resident's diagnosis included coronary artery disease, non-Alzheimer's dementia, encephalopathy, and alcohol dependence with persisting amnestic disorder. The Care Plan updated on 3/18/24, showed that Resident #6 had limited physical mobility related to alcohol abuse and dementia, with the discharge plan to go home. Staff directed to evaluate and record the resident's abilities. The resident admitted to the facility for a short term stay and required therapy services for strengthening and pain management. The Progress Note dated 3/14/24 at 10:58 AM showed that the resident discharged on that date without home health, follow up appointments or prescriptions. Social services explained that it was not how they arrange discharges, but the daughter said she needed to take him home because she could not afford the daily charges that would begin the following day. According to the Discharge Planning Review dated 3/4/24 at 1:53 PM, Social Services would arrange for home health services. The Discharge Summary dated 3/14/24 at 9:53 AM, indicated that the resident's insurance would not cover home health. The Reason for Discharge; daughter unable to make co pay. On 4/16/24 at 8:11 AM, a family member for Resident #6 said that he was discharged on [DATE]. She said that she got a call on 3/14/24 and was told that she had to come and get him because the insurance authorization had run out. It was her understanding that the resident would be getting physical therapy and occupational therapy in the home, but that didn't happen. When she came to pick him up, they did not have paperwork completed or a list of medications. She had to go to the primary doctor and get his list and take it to the pharmacy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024
NAME OF PROVIDER OR SUPPLIER Oakland Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 737 North Highway Oakland, IA 51560	

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) According to the MDS dated [DATE], Resident #4 admitted to the facility on [DATE] after short term hospital stay and had a BIMS score of 15. She used a walker for mobility and required substantial assistance with toileting, dressing and personal hygiene. The resident frequently incontinent of bladder and always incontinent of bowel. Diagnoses included deep venous thrombosis, renal insufficiency, seizure disorder, anxiety and depression. The Care Plan updated on 3/5/24, showed that Resident #4 at risk for falls, and staff directed to initiate frequent neurological assessments and bleeding evaluation per facility protocol. The discharge planning for home with home health, establish pre-discharge plan with the resident and family and evaluate progress and revise plan as indicated. History of pain, monitor and report resident complaints of pain Resident had a psychosocial well-being problem related to anxiety. The Progress Notes for the resident included the following: On 3/24/24 at 2:44 PM call received from Power of Attorney asking how resident is doing. Informed her resident has been good and has a planned discharge on 3/25/24. POA unaware of this. On 3/25/24 at 8:38 AM resident is now discharging on Wednesday or Thursday. (note lacked documentation of family notification) On 4/17/24 at 8:22 AM a Family Representative for Resident #4 said that shortly after Resident #4 came home, she was back in the hospital due to a fall, and was currently in another facility. Family said that she didn't know that the resident was being discharged on [DATE], until she called to talk to the resident and she told her that they were discharging her that day. She said that the Social Worker told her that the resident was being discharged because; there was nothing wrong with her. Home Health services had not been arranged for the resident. A facility policy dated 10/7/21 titled: Discharge Plan/Summary Voluntary. Social work should coordinate the discharge planning process. If the resident was discharging to home, social work should meet with the person accepting responsibility for the residents. Referrals needed should be made to home health, or to others based upon the needs of the resident. Nursing should meet with the person responsible for the resident at home and provide instruction to that person in regard to medications and treatments to be continued at home. Any unused medications that were currently ordered after discharge may be sent with the resident prior to discharge, according to state regulations.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, staff interview, clinical record review and facility policy review the facility failed to follow standard infection control practices related to proper hand hygiene for 1 of 3 residents reviewed. While providing incontinence cares for Resident #7, two Certified Nurse Aides (CNA) failed to change their gloves and perform hand hygiene after they had wiped the resident's legs and buttocks. The facility reported a census of 48 residents. Findings include: According to the Minimum data Set (MDS) dated [DATE], Resident #7 had a Brief interview for Mental Status (BIMS) score of 14 (intact cognitive ability). He required substantial assistance with dressing and hygiene and was totally dependent on staff for toileting and bathing. His diagnosis included anemia, coronary artery disease, heart failure renal insufficiency, diabetes mellitus, and cerebrovascular accident (CVA). The Care Plan updated on 2/29/24, showed that Resident #7 required assistance for meeting emotional intellectual, physical and social needs related to immobility. The resident required 2 staff assistance to turn and reposition in bed. He had peripheral vascular disease and staff were to monitor for injury infection or ulcers. The Progress Note dated 2/18/24 at 1:57 PM, showed that Resident #7 was on an antibiotic for acute cholecystitis (inflammation of the gall bladder). On 4/18/224 at 9:40 AM, Staff B, CNA, and Staff C transferred Resident #7 from the wheelchair to his bed with the use of a mechanical lift. Both staff members were wearing disposable gloves. After removing the sling and moving the machine, Staff B went to the opposite side of the bed. They removed the resident's pants and soiled brief. Staff B used disposable wipes and cleaned the front peritoneal area and penis. Without changing gloves, she held out her right hand for the resident to grab and with her left hand held his thigh. Staff C assisted to roll him over to expose his backside for Staff C to wipe. Staff C used disposable wipes to clean feces from his bottom. She gathered up the soiled brief and threw it in the trash. The CNA's continued to use the same gloves as they put on the clean brief, pulled up his pants. Staff B then removed her gloves but failed to use sanitizer. Staff C did not change her gloves, applied the sling and hooked the resident to the mechanical lift, drove the controls on the lift and then lowered him into the wheel chair. On 4/22 at 1:15 PM the Administrator acknowledged that the staff should have changed their gloves after performing incontinence cares. A facility policy titled: Hand Hygiene, last reviewed 4/28/22, indicated that hand hygiene would be performed following the clinical indications; before/after providing care, contact with blood, body fluids or contaminated surfaces.