

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 11/21/2024
NAME OF PROVIDER OR SUPPLIER Oakland Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673</p> <p>Based on the record review, resident interviews, staff interviews and policy review the facility failed to provide access to personal funds managed by the facility or manage personal funds deposited at the facility. The facility reported a census of 51 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #4 had a Brief Interview for Mental Status (BIMS) score of 14 indicating no cognitive impairment.</p> <p>On 11/18/24 at 12:13 PM Resident #4 stated he obtained money on Saturday this week from Staff K. Resident #4 stated Staff K worked in the business office across from the Administrator. Resident #4 stated residents could not get the money when the business office was closed. Resident #4 stated he could not get money at night or after the business office closes. Resident #4 stated the bank hours were 9am - 2pm Monday through Friday.</p> <p>2. The MDS assessment dated [DATE] documented Resident #21 had a BIMS score of 15 indicating no cognitive impairment.</p> <p>On 11/18/24 at 1:41 PM Resident #21 stated Staff K kept the money in the safe in her office and if Staff K or the Administrator was not at the facility there was no money available for any resident.</p> <p>On 11/19/24 at 10:49 AM Staff L ,Registered Nurse (RN), stated she had worked at the facility for about a year and a half. Staff L stated she worked the weekends and during the week 6am - 6pm. Staff L stated cash was not available in the evening or on the weekend when Staff K in HR was not at the facility. Staff L stated residents have asked for money on the weekend usually to break 20 dollar bills. Staff L stated the residents know they can not get cash when HR was not available.</p> <p>On 11/19/24 at 10:53 AM Staff F LPN stated the Administrator and she had spoken about making a lock box available for weekends and overnights. Staff F stated the cash would be counted like narcotics and locked up. Staff F stated she had worked at the facility for 2 years.</p> <p>(continued on next page)</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 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/19/24 at 10:58 AM Staff K, Business Office Manager (BOM) stated she had worked at the facility since 9/15/24. Staff K stated residents did not have access to their funds unless she was working. Staff K stated the future plan is that there will be a binder with prepared funds available for the residents. Staff K stated she worked on the weekend when she is the manager on duty (MOD). Staff K stated she had worked every day in the month of November. Staff K stated the bank hours are 9am till 2pm. Staff K stated if she was at the facility and it was not between 9am and 2pm she would get the residents money. Staff K stated bank hours are 9am - 2pm on the weekend if she is the MOD that weekend as well. Staff K stated she had residents ask for money on the weekend and in the evening when she was working. Staff K stated that there was a maximum of \$50.00 a day limit for each resident. Staff K stated the only residents who are new or she had not had the conversation with already have asked for more than \$50.00 in a day. Staff K stated there was only one dollar in the safe right now. Staff K stated there was a resident right now who requested \$5.00 and was not currently available and another resident also who would like \$50.00. Staff K stated there were grievances related to the money not being available in the petty cash.</p> <p>On 11/19/24 at 11:36 AM Staff M, Social Worker stated she was an aide that started in 2017 and started the position as a social worker in June or July of this year. Staff M stated she was the current grievance officer. Staff M stated there were 7 grievances related to personal funds being available for the month of November. Staff M stated she gave the grievance to the Administrator when it had to do with personal funds. Staff M stated the facility increased the petty cash amount and set banking hours. Staff M stated banking hours were set so that Staff K could be accessible for the residents.</p> <p>Review of the document dated 11/24 titled, Grievance/Missing Property Monthly Tracking Log documented 7 residents filed grievances on 11/6/24 that they had been trying to get money from the BOM for a few days. Outcome resolution explained as the BOM was new and struggled to meet cash demands. Increased petty cash amount and set banking hours.</p> <p>On 11/19/24 11:16 AM the Administrator stated as long as there is someone at the facility that has access to the safe the residents have access to their personal funds. The Administrator stated Staff K and the Administrator had access to the residents personal funds. The Administrator stated there was no access to the residents personal funds on the weekends or in the evening when the Administrator or Staff K were not at the facility. The Administrator stated it had happened once before that residents had wanted money and it was not available for them to obtain. The Administrator stated she went to the bank and withdrew money so the residents had the money at that time. The Administrator stated there was a grievance written related to a resident not having funds available. The Administrator stated the time that this happened Staff K was in training and meetings and was not available to give them the money at that minute. The Administrator stated the resident did not come and complain to her about the funds not being available. The Administrator stated as soon as she found out she obtained the funds for the resident that day. The Administrator stated she did not remember the of the resident that complained of personal funds that day off the top of her head. The Administrator stated there was a process that was being worked on currently but does not have a finalized policy currently.</p> <p>(continued on next page)</p>		

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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of undated policy titled Business Office - Resident Trust Fund Policy and Procedure documented residents of a Skilled Nursing Center are to have their funds managed and personal spending money available to them. The Center shall maintain a Resident Trust Cash Box to provide for cash withdrawals of the resident. This will be kept in a separate cash box from all other Center petty cash. The Resident Trust Cash Box will have a set maximum balance to be established by the corporate office. If the Resident Trust Cash Box maximum fund should need to be increased, a request must be sent to the corporate office. When the Resident Trust Cash Box is replenished, funds should be used from the Resident Trust Bank account. The Resident Trust Cash Box funds will not be comingled with any other Center petty cash. When writing checks to replenish trust cash box: Write a check to Cash or payable to the Center and take to the Center's local bank where the Resident Trust account is held. If the bank holding the Resident Trust account isn't local, write a check to the Center and cash at the Center's local bank where the Center operating petty cash account is held. Any checks written out of the RFMS accounts must be signed by two authorized signers and may not be signed by the business office manager or the account custodian. Residents shall have the right, during normal banking office hours, to be informed of the balance in the Resident Trust Fund, as well as make deposits. The resident banking hours are to be posted at the Business Office. Residents shall be able to make withdrawals from their account at any time. The Center will honor any request of resident funds \$50 (\$100 for Medicare residents) or less that same day and any request of resident funds over \$50 (\$100 for Medicare residents) within 3 business days of the request.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>47079</p> <p>Based on observations, and staff interview, the facility failed to provide maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The facility reported a census of 51 residents.</p> <p>Findings include:</p> <p>On 11/18/24 at 10:00 am, an observation revealed multiple areas of missing or damaged floor tile in the north hall.</p> <p>On 11/19/24, a follow-up observation revealed the flooring tile had not been repaired or replaced.</p> <p>On 11/20/24 at 2:09 pm, the Maintenance Director stated he was responsible for minor repairs but major repairs required a contract company respective to the repair need. He stated cosmetic repairs were entered into a facility application available to all staff but indicated there were no unresolved building repairs. He also stated maintenance rounds were performed on a monthly basis. At 2:17 pm, he stated floor tile repair was a task he could repair and added he had no reason for why it had not been repaired.</p> <p>On 11/21/24 at 1:03 pm, the Corporate Director of Operations stated the facility did not have a policy specifically for homelike environment or maintenance repairs.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673</p> <p>Based on clinical record review, policy review, and staff interviews the facility failed to represent an accurate assessment of the resident's status during the observation period of the Minimum Data Set (MDS) by not accurately assessing the use of an anticoagulant, insulin or an indwelling catheter for 3 of 10 residents reviewed (Resident #25, #32 and #48). The facility reported a census of 51 residents.</p> <p>Finding include:</p> <p>1. The MDS assessment dated [DATE] for Resident #25 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment.</p> <p>Review of Resident #25's MDS dated [DATE] documented use of anticoagulant therapy by Resident #25.</p> <p>Review of Resident #25's Medication Administration Record (MAR) documented a physician's order for clopidogrel bisulfate (Plavix) oral tablet 75 mg, an anti-platelet. Review of Resident #25's MAR documented no physician order for use of an anti-coagulant.</p> <p>2. The MDS assessment dated [DATE] for Resident #32 documented a BIMS score of 15 indicating no cognitive impairment.</p> <p>Review of Resident #32's MDS dated [DATE] documented use of insulin therapy by Resident #32.</p> <p>Review of Resident #32's MAR documented a physician's order for Trulicity Subcutaneous Solution Pen-injector 4.5 MG/0.5ML. Review of Resident #32's MAR documented no physician order for insulin.</p> <p>On 11/19/24 at 1:39 PM the ADON stated Resident #25 was on Plavix. The ADON stated she thought Plavix was an anticoagulant and had not realized it was an anti-platelet. The ADON acknowledged that the MDS was coded incorrectly for Resident #25. The ADON stated Resident #32 had never been on insulin since he entered the facility. The ADON stated Resident #32 was on Trulicity and that is why Resident #32's MDS was coded that way. The ADON acknowledged that the MDS was coded in error when documented as receiving insulin 7 days during the last 7 days of the MDS for Resident #32.</p> <p>On 11/19/24 at 1:44 PM the DON stated that Plavix was an antiplatelet. The DON acknowledged the MDS was coded incorrectly with the Plavix as an anticoagulant for Resident #25 and the Trulicity as an insulin for Resident #32.</p> <p>Review of policy revised 4/26/23 titled, MDS 3.0 documented the MDS Coordinator, in conjunction with the Interdisciplinary Team (IDT), is expected to complete assessments using the MDS 3.0 Resident Assessment Instrument (RAI) specified by the state in compliance with the MDS 3.0 RAI User's Manual guidelines. Everyone completing a portion of the assessment must sign and certify the accuracy of the portion of the assessment they completed.</p> <p>49628</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. The MDS of Resident #48 dated 10/17/24 documented in Section H - Bladder and Bowel the resident had an external catheter.</p> <p>The Care Plan of Resident #48, created on 10/10/24 and revised on 10/25/24, documented the resident required catheterization indwelling due to diagnosis of: neurogenic bladder.</p> <p>The MAR for Resident #48 for the month of 11/24 failed to reveal documentation of an external catheter. The MAR reflected that the resident required a Size 16fr 10ml bulb catheter with a diagnosis of a neurogenic bladder.</p> <p>On 11/20/24 at 10:25 AM the Director of Nursing (DON) and the Regional Nurse Consultant confirmed Resident #48 had an indwelling catheter. The staff stated the Care Plan was correct and the MDS was coded incorrectly.</p> <p>The facility policy, MDS 3.0, revised 4/26/23, revealed the assessment is completed using direct observation, communication with resident/family/staff, and documentation in the Medical Record. The document further revealed that the completion of the MDS and Care Area Assessments (CAA) were used to develop a comprehensive person-centered care plan.</p>

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<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** 47673</p> <p>Based on clinical record review, policy review and staff interviews the facility failed to provide a comprehensive care plan that included goals or interventions for enhanced barrier precautions (EBP) for a resident with a catheter and use of an anti-platelet for 2 of 10 residents reviewed (Resident #25 and #48). The facility reported a census of 51 residents.</p> <p>Finding include:</p> <p>1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #25 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment.</p> <p>Review of Resident #25's Medication Administration Record (MAR) documented a physician's order for clopidogrel bisulfate (Plavix) oral tablet 75 mg an anti-platelet.</p> <p>Review of Resident #25's Care Plan documented no focus, goals or interventions for anti-platelet therapy.</p> <p>On 11/19/24 at 1:44 PM the DON stated that Plavix was an antiplatelet. The DON stated Resident #25 should have a Care Plan in place related to the risk for bleeding on the Care Plan. The DON acknowledged Resident #25 did not have a Care Plan with a focus, goal, or interventions in place related to use of antiplatelet therapy.</p> <p>Review of a policy reviewed on 10/23/19 titled, Comprehensive Person-Centered Care Plan documented Each resident will have a person centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care.</p> <p>49628</p> <p>2. The MDS assessment for Resident #48 dated 10/17/24 identified a BIMS score of 12 which indicated moderate cognitive impairment. The MDS documented diagnoses that included: septicemia, multiple sclerosis, pressure ulcer of right hip (unstageable), bacteremia, neurogenic bladder, urinary tract infection, and rhabdomyolysis.</p> <p>The Care Plan printed on 11/20/24 lacked documentation pertaining to enhanced barrier precautions (EBP). The document did contain a treatment regime for a wound to the right hip and coccyx/bilateral buttocks. The document further revealed the resident had an indwelling catheter.</p> <p>On 11/20/24 at 2:15 PM the Director of Nursing (DON) stated the need for EBP should be noted in the resident's care plan.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628</p> <p>Based on observations, clinical record review, and staff interviews, the facility failed to protect residents from possible accidents and injuries for 2 of 17 residents (Resident #8, and #15) reviewed. The facility reported a census of 51 residents.</p> <p>Findings include:</p> <p>1. Review of Resident #8's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating normal cognitive function. Section GG, Functional Abilities, disclosed the resident utilized a manual wheelchair (w/c) and required substantial/maximal assistance.</p> <p>Resident #8's Care Plan dated 7/13/24 revealed the resident required the use of a Hoyer for transfers.</p> <p>Observation on 11/19/24 at 11:42 AM revealed Staff E, Certified Nursing Assistant (CNA), pushing Resident #8 in his w/c without foot pedals from his bedroom to the dining room.</p> <p>On 11/19/24 at 11:53 AM Staff E stated she was a contract staff, but had worked here many times. The staff stated she had been provided on training from the facility on facility expectations on use of w/c's, and transfers.</p> <p>2. Review of Resident #15's MDS dated [DATE] revealed a BIMS score of 7 indicating severe cognitive impairment. Section GG, Functional Abilities, disclosed the resident utilized a manual wheelchair (w/c) and could self propel 150' with setup assistance.</p> <p>Resident #15's Care Plan revealed the resident should wear appropriate footwear with use of a w/c and during transfers.</p> <p>Observation on 11/19/24 at 7:55 AM revealed Staff F, Licensed Practical Nurse (LPN), pushing Resident #15 from the dining room to the nurses station and back without foot pedals. The distance was approximately 8' in each direction.</p> <p>Observation on 11/19/24 at 2:15 PM revealed Resident #15 self propelling his w/c from the smoking area into the building.</p> <p>Observation on 11/20/24 at 11:40 PM revealed Resident #15 self propelling his w/c within the facility.</p> <p>On 11/19/24 at 2:05 PM Staff I, housekeeping, stated staff could not push residents' w/c's without their foot pedals.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/21/24 at 11:40 AM Staff B, Registered Nurse (RN), stated a resident must have foot pedals on to be pushed in a wheelchair. The staff stated this had been trained in CNA school as well as the facility.</p> <p>On 11/20/24 at 10:50 AM the Director of Nursing (DON) and Assistant Director of Nursing (ADON) stated the expectation was for staff to utilize foot pedals when pushing residents in their w/c's. The DON stated education had previously been provided to staff regarding location of extra foot pedals and use of foot pedals.</p> <p>On 11/20/24 at 12:14 PM the Administrator stated staff should not push residents without foot pedals on their w/c's.</p> <p>On 11/21/24 at 12:45 PM the Administrator stated the facility did not have a policy for foot pedals and w/c propulsion. The facility followed Standards of Practice.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>47079</p> <p>Based on observations, and staff interviews, the facility failed to provide food served by a method to maintain a safe and appetizing temperature. The facility reported a census of 51.</p> <p>Findings include:</p> <p>On 11/20/24 at 7:32 am, Staff A, Cook, checked the temperature of the breakfast menu items. The sausage gravy temperature was recorded at 180 Fahrenheit (F).</p> <p>On 11/20/24 at 8:33 am, Staff A checked the temperature of the remaining breakfast items. The sausage gravy temperature was recorded at 130 F.</p> <p>On 11/20/24 at 3:11 pm, the Dietary Manager stated staff should check the food temperatures before, during, and after meal service to ensure the food maintains regulatory temperature.</p> <p>On 11/21/24 at 1:03 pm, the Corporate Director of Operations stated the facility did not have a policy specific to holding temperatures for meal service.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079</p> <p>Based on observations, interviews, and policy review, the facility failed to properly label stored food, failed to maintain sanitary practices by using the dedicated hand hygiene sink to fill a pitcher of water for resident use, and failed to ensure the appropriate amount of sanitizer solution was used to effectively sanitize food preparation surfaces. The facility reported a census of 51 residents.</p> <p>Findings include:</p> <p>On 11/18/24 at 11:15 am, Staff B, Registered Nurse (RN) was observed using the kitchen hand hygiene sink and filled a pitcher of water for resident use. Staff C, Cook, asked Staff B if she was supposed to use the hand hygiene sink for resident water to which Staff B replied she was instructed to use the (hand hygiene) sink.</p> <p>On 11/20/24 at 6:30 am, a kitchen observation revealed the [NAME] refrigerator contained the following items:</p> <ul style="list-style-type: none"> a) An unlabeled package of round, pink meat. b) An unlabeled, undated, tan pitcher of liquid in the refrigerator. <p>On 11/20/24 at 6:35 am, the pantry contained the following item:</p> <ul style="list-style-type: none"> a) Two (2) clear, unlabeled bags of multicolored, ring-shaped items <p>On 11/20/24 at 8:45 am, Staff D, dietary aide (DA) performed a sanitizer solution concentration check. The documented results were 100 parts-per-million (ppm).</p> <p>During a review of the kitchen policy dated 2010 on 11/30/22 at 3:00 PM, page 10 of the policy revealed that the cook is responsible for properly storing, preparing, and handling food.</p> <p>On 11/20/24 at 3:11 pm, the Dietary Manager (DM) stated staff should date and label everything. She also stated staff should not use the hand hygiene sink for non-hand hygiene purposes.</p> <p>On 11/21/24 at 8:25 am, the DM stated staff should prepare a new bucket of sanitizer prior to each meal service use.</p> <p>The manufacturer's AutoChlor chlorine Precautionary Statement label indicated the solution should be 200 ppm to be effective at sanitizing food preparation surfaces.</p> <p>A policy titled Nutritional Services Sanitation dated 3/31/21 indicated equipment shall be cleaned, sanitized, delimed, etc. in accordance with manufacturer recommendations. It also indicated detergents and sanitizers shall be used in the correct dilutions consistent with Federal and State guidelines and ordinances governing food service.</p> <p>(continued on next page)</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>A policy titled Refrigeration dated 3/31/21 did not include dating and labeling requirements for stored food other than leftovers.</p> <p>A policy titled Nutritional Service Hand Hygiene 3/31/21 directed staff to clean their hands and wrist area for at least 20 seconds in a designated handwashing sink (which shall not include a food preparation sink, pot washing sink, a service sink or an area designated to dispose of mop water).</p>		

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NAME OF PROVIDER OR SUPPLIER Oakland Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 737 North Highway Oakland, IA 51560	
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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>47673</p> <p>Based on the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (April 1 - June 30) review, facility staffing reports review, and staff interviews, the facility failed to submit accurate staff reports for the PBJ Staffing Data Report. The facility reported a census of 51 residents.</p> <p>Findings include:</p> <p>The PBJ Staffing Data Report run date 11/13/24 for quarter 3 2024 triggered for excessively low weekend staffing and one star staffing rating.</p> <p>Review of weekend staffing schedules for quarter 3, months of April, May, and June revealed equal staffing during the week and the weekend.</p> <p>On 11/20/24 at 2:01 PM the Administrator stated the facility followed the per patient day (PPD) formula defined in the facility assessment for staff numbers and there is no change in the numbers for staffing on the weekend. The Administrator acknowledged the PBJ was reported inaccurately. The Administrator stated the facility was going to review the PBJ to ensure the reported information was accurate.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49628</p> <p>Based on observations, clinical record review, staff interviews and policy reviews the facility failed to implement appropriate hand hygiene and infection control practices to mitigate the spread of pathogens during resident cares (Resident #48), medication administration and laundry delivery. The facility reported a census of 51.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment for Resident #48 dated 10/17/24 identified a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. The MDS documented diagnoses that included: septicemia, multiple sclerosis, pressure ulcer of right hip, unstageable, bacteremia, neurogenic bladder, urinary tract infection and rhabdomyolysis.</p> <p>Resident #48's Care Plan revealed the resident had an indwelling catheter and a wound to the right hip and coccyx/bilateral buttocks.</p> <p>The Catholic Health Initiatives (CHI) laboratory report dated 10/14/24 revealed the right hip had moderate mixed microbial flora with Moderate Gram Negative Rods (2 colony types) including Probable Proteus species.</p> <p>Observation on 11/18/24 at 2:00 PM noted Resident #48 did not have signage posted that indicated the resident required enhanced barrier precautions (EBP). On the back of the resident's door contained personal protective equipment (PPE) including gloves and gowns.</p> <p>During a continuous observation on 11/19/24 at 1:36 PM Staff B, Registered Nurse (RN), and Staff G, RN, completed Resident #48's wound care on the right hip. Staff G stated the resident is currently on antibiotics due to the infection in the wound and had been admitted with the wound.</p> <p>a. Staff B and Staff G entered the resident's room, washed their hands, and donned gloves.</p> <p>b. Staff B and Staff G assisted the resident into standing, removed her pants and transferred into the bed.</p> <p>c. Staff B removed gloves, completed hand sanitizer, and donned new gloves.</p> <p>d. Staff G removed gloves and donned new gloves - no hand hygiene.</p> <p>e. Staff G completed Vashe wash for 5 minutes.</p> <p>f. Staff B managed the timer.</p> <p>g. Staff G removed gloves and donned new gloves without hand hygiene, and applied Santyl.</p> <p>h. Staff B applied zinc to the wound area.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>i. Staff G removed gloves, donned gloves without hand hygiene, and applied dry dressing.</p> <p>j. Staff B dropped an adhesive bandage, picked up, threw it away, removed gloves, and left the room to obtain a new adhesive.</p> <p>k. Staff B and G donned gloves without hand hygiene, assisted the resident with clothing management, and transferred to the wheelchair.</p> <p>l. Staff B and G removed gloves, and gathered trash.</p> <p>On 11/20/24 at 10:20 AM the Director of Nursing (DON) and Assistant Director of Nursing (ADON)/Infection Preventionist (IP) stated the Resident #48 would have EBP with the wound and the indwelling catheter. The DON and ADON/IP were unable to recall if there was a sign posted at the resident's door, but the PPE was in the resident's room. The DON and ADON/IP stated they would expect nursing staff to wear PPE during wound care including gloves and gown. The staff stated hand hygiene should be completed before donning gloves and upon removal.</p> <p>The facility document, Policy and Procedure Handwashing, dated 2/16, revealed the use of alcohol-based hand rub before applying gloves and after removing gloves or other PPE.</p> <p>The facility document, Enhanced Barrier Precautions, reviewed 5/24, revealed the use of gowns and gloves for high-contact resident care activities as indicated, when Contact Precautions do not otherwise apply, for facility residents with wounds and/or indwelling medical devices regardless of multidrug-resistant organism (MDRO) colonization as well as for residents with MDRO infection/colonization.</p> <p>The Centers for Disease Control and Prevention website document titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), updated 7/12/22 revealed recent changes included, additional rationale for the use of Enhanced Barrier Precautions (EBP) in nursing homes, including the high prevalence of multidrug-resistant organism (MDRO) colonization among residents in this setting. Expanded residents for whom EBP applies to include any resident with an indwelling medical device or wound (regardless of MDRO colonization or infection status). Expanded MDROs for which EBP applies. Clarified that, in the majority of situations, EBP are to be continued for the duration of a resident's admission. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status and Infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care.</p> <p>2. Continuous observation on 11/19/24 beginning at 6:49 AM of Staff F, Licensed Practical Nurse (LPN), completing medication administration:</p> <p>a. Staff F poured Vitamin D from a stock bottle into the lid needing 2 pills. Staff F spilled a third pill onto the medication cart. Using an ungloved hand the staff picked up the pill and placed it back in the bottle, and continued to dispense medications. No hand hygiene was observed.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. Staff F dropped an aspirin 325 mg onto the medication cart. Staff F with an ungloved hand picked up the medication, placed it in the medication cup, and continued to dispense medications. No hand hygiene was observed.</p> <p>c. Staff F dispensed an injection medication without use of gloves or hand sanitizer.</p> <p>d. Staff F prepared to dispense an injectable medication, was prompted to don gloves for completion. The staff proceeded to don gloves without hand hygiene.</p> <p>Continuous observation on 11/19/24 beginning at 7:27 AM of Staff H, Certified Medication Technician (CMT), completing medication administration.</p> <p>a. Staff H dispensed stock medication with an extra pill falling into the lid. Staff H donned a single glove, removed the pill, disposed of the pill, and removed the single glove. No hand hygiene completed.</p> <p>b. Staff H donned gloves without hand hygiene to crush medications. A single pill fell on to the medication cart, the staff picked up the pill, placed it in the medication bag, and continued crushing medications. Staff H removed her gloves and proceeded to mix the medications.</p> <p>Continuous observation on 11/19/24 beginning at 9:27 AM of Staff G, RN, completing medication administration:</p> <p>a. Staff G donned and doffed gloves for eye drop medication without hand hygiene.</p> <p>b. Staff G donned and doffed gloves for application of a topical cream without hand hygiene.</p> <p>On 11/20/24 at 11:50 AM the DON and ADON/IP stated nursing staff should wear gloves when handling medications rather than using bare hands to pick up pills. The staff stated if medications were spilled, medications should be disposed of as per facility policy/procedure, and not put into medication cups or returned to stock pill bottles. The DON and ADON/IP stated staff should complete hand hygiene before and after use of gloves.</p> <p>The facility policy Medication Administration-Preparation and General Guidelines, revised 8/14, revealed hand sanitization is completed between hand washings, returning to the medication cart, and after each medication pass. The document identified hand hygiene was to be completed before putting on gloves and upon removal for administration of topical, ophthalmic, and injectable medications.</p> <p>3. Multiple observations of laundry delivery revealed the following:</p> <p>a. Observed on 11/18/24 at 12:14 PM Staff I, housekeeping, carried laundry from basement laundry room to linen closets. The laundry was in baskets and not in baskets. Laundry not in baskets was carried close to Staff I's face. The laundry was not covered during delivery.</p> <p>b. Observed on 11/18/24 at 3:32 PM Staff I deliver resident hanging laundry uncovered to multiple rooms. The staff carried all laundry into multiple resident rooms. Staff I utilized hand sanitizer 1 time between 4 rooms. Laundry was not covered during delivery.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. Observed on 11/18/24 at 3:38 PM Staff I deliver resident hanging laundry to resident rooms. Staff I hung laundry on the handrail in the hallway with the residents' clothes touching the floor. Staff I utilized hand sanitizer 1 time amongst 5 rooms. Laundry was not covered during delivery.</p> <p>d. Observed on 11/19/24 at 11:21 AM Staff J delivered resident hanging laundry to resident rooms. Staff carried the uncovered laundry in and out of multiple resident rooms.</p> <p>On 11/20/24 at 12:16 PM the Maintenance Director stated staff will place clothes on hangers or in baskets to carry upstairs to the resident rooms from the laundry in the basement. The Maintenance Director stated the laundry staff do not cover the clean laundry before delivery.</p> <p>On 11/20/24 at 2:25 PM the DON and the ADON/IP expected that laundry would be covered when being delivered. The staff stated clean laundry should neither be carried near a staff's face nor touching the floor.</p> <p>The facility policy, Handling Linen/Laundry, reviewed 7/2/24 revealed linen and laundry should be handled, transported, and stored to prevent the spread of infection. The document revealed employees should be educated at a minimum of transportation of clean linens and laundry. The document informed the reader that clean linen/laundry shall be covered during transport to ensure cleanliness and protect against dust and soilage.</p>		