STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165439	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakview Nursing and Rehabilitation	1212 Indian Hills Drive Burlington, IA 52601

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45338 Based on clinical record review, staff interview, and facility policy review the facility failed to ensure use of antiplatelet medication and seizures were included on the resident's comprehensive plan of care for two of thirteen residents reviewed for care plans (Resident #16, Resident #20). The facility reported a census of 49 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment for Resident #16 dated 6/20/24 revealed the resident scored 12 out of 15 on a Brief Interview for Mental Status (BIMS) assessment, which indicated moderately impaired cognition. Per this assessment, the resident took antiplatelet medication. The Physician Order dated 6/14/24 revealed, Clopidogrel Bisulfate (generic Plavix, an antiplatelet medication) Oral Tablet 75 MG (milligram) with direction to give 1 tablet by mouth one time a day. The Physician Order dated 6/14/24 revealed, Aspirin EC (enteric coated) Tablet Delayed Release 81 MG with directions to give 1 tablet by mouth one time a day. Review of the resident's Medication Administration Record (MAR) dated June 2024 and July 2024 revealed the resident received both medications on 6/14/24 to 6/30/24, and also on 7/1/24 to 7/11/24. On 7/11/24 at 12:07 PM during an interview with the MDS Coordinator, the MDS Coordinator acknowledged antiplatelet medication should be on the care plan. 2. Review of the MDS assessment for Resident #20 dated 6/15/24 revealed the resident scored 15 out of 15 on a BIMS exam, which indicated intact cognition. Review of the Physician Order dated 6/14/24 revealed, Phenytoin Sodium (generic Dilantin, an antiseizure medication) Extended Capsule 100 MG (milligram) with directions to give 1 capsule by mouth three times a day related to altered mental status. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Office/Clinic Notes by the Advanced Registered Nurse Practitioner (ARNP) dated 6/20/24 revealed, Medications were adjusted in the hospital and Dilantin was added for possible observed seizure activity. Review of the Assessment/Plan section of the note documented the following per the 3.Seizure section: Started on phenytoin 100 mg 3 times daily. She is follow-up with neurology per discharge summary, June 24. Review of the Neurology Note dated 6/25/24 revealed, in part, [Resident #20] is on Dilantin 3 times daily for subclinical seizures mainly for level to be checked to make sure is in a therapeutic range. On 7/10/24 at 10:02 AM, review of the resident's care plan did not address seizures. On 7/11/24 at 12:09 PM, the MDS Coordinator acknowledged seizure disorder/medications for seizures should be on the care plan. Review of the Facility Policy titled Comprehensive Care Plan, dated 8/30/21 revised on 7/18/22, revealed, Care, treatment and services shall be planned to ensure that they are individualized to the resident's needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45338 Based on clinical record review, staff interview, and facility policy review the facility failed to ensure the Care Plan revisions to indicate; a resident use of prophylactic antibiotics, resident wandering, and the presence of pressure ulcers for 3 of 13 residents reviewed for Care Plans (Resident #29, Resident #45, and Resident #9). The facility reported a census of 49 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment for Resident #45, dated 6/13/24, revealed the resident scored 4 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment the resident had an indwelling catheter and took an antibiotic. Review of the Physician Order dated 4/19/24 revealed, cephalexin (an antibiotic) oral tablet 250 MG give 1 tablet by mouth one time a day for prophylactic (medication used to prevent infection.) Review of the Office/Clinic Notes for Resident #45, dated 6/20/24, revealed, a Chronic Foley due to failed void trial and continues on cephalexin 250 mg (milligram) daily for prophylaxis. Review of the Care Plan for Resident #45 did not address use of a prophylactic antibiotic for the resident. On 7/12/24 at 12:09 PM, the MDS Coordinator acknowledged prophylactic antibiotics should be on the care plan. Review of the Facility Policy titled Comprehensive Care Plan, dated 8/30/21 and revised 7/18/22, revealed, the facility shall provide an individualized, interdisciplinary plan of care for all residents that shall be appropriate to the resident's needs, strengths, results of diagnostic testing, limitations and goals. 48374 2. The MDS assessment, dated 5/23/2024, for Resident #29 listed diagnoses included: progressive supranuclear ophthalmoplegia (neurodegenerative disease), adjustment disorder with anxiety, and obsessive-compulsive disorder. The assessment indicated the resident walks independently with a walker. The BIMS score of 11 out of 15 indicating moderately impaired cognition. A Progress Note dated 5/3/2024 at 10:10 PM, revealed Resident (Resident #29) requested to go outside to sit this evening due to increased agitation. Resident ambulated further than anticipated and an LPN staff member escorted the resident back to the building. Resident was educated on the safety risks of ambulating outside without a staff members assistance. Wander guard placed on residents left ankle for safety reasons (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the clinical record revealed a Physician's Order, dated 5/6/24, for Wanderguard for every shift. The Care Plan, dated 6/14/24, included a Focus Area for wandering. Interventions included: a. Avoid overstimulation. (Noise, crowding, other physically aggressive residents). b. Convey an attitude of acceptance toward the resident. c. Develop a pathway for resident to follow. Keep pathway free from obstacles. d. If resident looks for family/significant other, reassure that others know where to find him/her. e. Maintain a calm environment and approach to the resident. f. Redirect resident from exit doors as needed. g. Wander guard. On 07/08/24 at 10:45 AM Resident #29 was interviewed. Resident #29 shared she likes to go outside but they won't let her go out by herself anymore. Resident indicated she left the building on several occasions but did not leave the property. The resident shared she likes to walk around and used to walk all around on her parent's land. Resident advised she had gotten 4 wander guards off and now she is watched all the time so she doesn't go out different doors. Resident shared the staff keep a close eye on her now. Resident shared she does not feel there is enough staff to take her outside when she wants to go out On 07/10/24 at 09:05 AM The Facility Nurse Consultant was queried. She advised the resident is very mobile and likes to walk around all the time. She had gotten the door code and went outside so she has a wander guard now. Resident has a wander guard on her wrist and one on her walker. The resident has never eloped but has tested the boundaries a bit and it started to make staff uncomfortable so she can't go outside by herself anymore. For awhile she could go out on her own. Activity staff take her outside. On 07/11/24 at 12:22 PM The Administrator was interviewed regarding Resident #29 and wandering concerns. On 5/3/24 Resident #29 was outside with staff and she walked beyond a point the staff member was comfortable with so the staff member brought her back in the building. The Resident did not go off the property and was never out of sight. The wander guard was placed on the resident for safety measures. We have several interventions for her. The Administrator advised the staff member responsible for completing Care Plans is new to that position and when the facility conducted a care plan audit they discovered the wandering concerns and interventions with Resident #29, in error, had not been added to the resident's care plan. 48888 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The MDS assessment for Resident #9, dated 6/03/24, lacked identification of unhealed pressure injuries and indicated no risk for the development of pressure injuries. The MDS identified Resident #9 had a surgical wound and required a pressure reducing device for chair and bed, surgical wound care, the application of nonsurgical dressings, and ointment or medications applied (other than to feet). The MDS revealed Resident #9 required substantial to maximal staff assistance to transfer and partial to moderate staff assistance for bed mobility. The diagnoses listed for Resident #9 included: diabetes mellitus, cerebrovascular accident (CVA or Stroke), heart failure, and an encounter for orthopedic aftercare. The Care Plan, revised on 7/03/24, indicated Resident #9 at risk for skin breakdown related to fractured hip, previous cerebrovascular accident, weakness, and pain. Interventions included: monitor and report signs of skin breakdown, and complete skin treatments as ordered. The Care Plan lacked identification of pressure injuries or unhealed skin impairments. The Admission Nursing Assessment, dated 5/28/24, revealed Resident #9 right heel noted to have an open area that measured 0.8 centimeters (cm) by 0.8 cm. The Admission Assessment identified bruises on left hand, left lower leg, right lower leg, an open area on front of right lower leg, and intravenous infiltration site to the right antecubital (common area on arm for IV insertion). Assessment lacked identification of pressure injuries. A document titled, Wound and Skin Healing Record, dated 5/28/24, identified a right heel Stage 2 pressure injury that measured 0.8 cm by 0.8 cm with 0.1 cm depth. The Wound/Skin Healing Record, dated 6/18/24, revealed a Stage 2 pressure injury noted to left heel that measured 3.8 cm by 3.4 cm, had small amount of serosanguineous drainage, wound bed and surrounding skin documented as normal tissue. The Wound/Skin Healing Record, dated 6/19/24, revealed identification of a blood blister to top of right first toe, document lacked wound measurement or assessment of tissue, the surrounding skin, or drainage type. On 7/17/24 at 1:00 PM, Staff I, Registered Nurse and MDS Coordinator revealed when residents are admitted , she would review the Admission Assessment and Nursing Progress Notes to determine if wounds were present on admission. Staff I revealed wounds and pressure injuries should be included in the Care Plan with indication of wound type and interventions. Staff I confirmed Resident #9's Care Plan lacked identification of pressure injuries or unhealed wounds. The facility policy titled, Pressure Ulcer Prevention Policy, not dated, revealed that pressure injury interventions shall be incorporated into the resident's plan of care, evaluated, and revised as the condition of the resident indicates.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48374 Based on clinical record review, policy review, and staff interviews the facility failed to administer medications as directed for one of one residents (Resident #254) reviewed. The facility reported a census of 49 residents. Findings Include: The Admission Minimum Data Set (MDS) assessment, dated 6/27/2024, list of diagnoses included: hypokalemia (low potassium), paroxysmal atria fibrillation (irregular heartbeat), hypotension, and adult failure to thrive. The MDS listed a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating a moderate cognitive impairment. A review of the clinical record revealed Resident #254 admitted to the facility on [DATE] at 3:00 PM. The Physician Order dated 6/21/2024 documented, Metoprolol Tartrate Oral Tablet 50 mg related to Essential (Primary) Hypertension. Give 2 tablet by mouth two times a day. The Physician Order dated 6/21/2024 documented, Levetiracetam Oral Tablet 500 mg related to Alcohol use, unspecified, uncomplicated. Give 1 tablet by mouth two times a day. The Physician Order dated 6/21/2024 documented, Potassium Chloride ER Tablet Extended Release 10 MEQ (milliequivalent). Give 1 tablet via PEG-Tube two times a day related to hypokalemia. The June 2024 Medication Administration Record (MAR) documented on 6/21/24 Resident #254 had not received the prescribed levetiracetam 500 mg, metroprolol tartrate 50 mg, and potassium chloride 10 MEQ. A review of the (EHR) revealed the following Orders-Administration Notes: a. At 12:26 AM Metoprolol Tartrate Oral Tablet 50 MG Give 2 tablet by mouth two times a day .NA (not available) not sent from pharmacy. b. At 12:26 AM levETIRAcetam Oral Tablet 500 MG Give 1 tablet by mouth two times a day .NA not sent with pharmacy c. At 12:27 AM Potassium Chloride ER Tablet Extended Release 10 MEQ Give 1 tablet via PEG-Tube two times a day .NA not sent from pharmacy During an interview on 07/11/24 at 3:40 PM, the Nurse Consultant stated Resident #254 may have admitted to the facility past the cut off time for the day when they pharmacy does not get the medications to the facility. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/11/2024 at 4:10 PM, the Nurse Consultant provided the Packing Slip from the pharmacy documenting all of the prescribed medications were delivered to the facility together. The nurse that omitted the three medications did so in error. The facility policy, revised on 4/1/23, titled Medication Administration revealed the Policy statement included: Medications shall be administered per physician order.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on clinical record review, staff interviews, and facility policy review, the facility failed to provide monitoring, assessment and intervention services causing a pressure ulcer present on admission to worsen, and the development of new pressure ulcers. Resident #9 admitted on [DATE] with a Stage 2 pressure ulcer present on the right heel. The pressure ulcer deteriorated to a Stage 3 by 7/5/24. The clinical record revealed the resident experienced pain and a referral to the wound clinic. During the first wound clinic appointment on 6/11/24, the right heal pressure ulcer was not assessed or treated. The facility did not follow up with the clinic. On 6/25/24, the wound clinic assessed the right heel as a Stage 3 pressure ulcer with necrotic (dark, dead tissue) tissue and identified a new unstageable pressure area on the left heel, and Stage 3 Pressure ulcers on bilateral buttocks. On 7/5/24, both the right and left heels presented with necrotic tissue. The facility reported a census of 49 residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) on 7/16/24 at 4:15 PM. The IJ began on 5/28/24. Facility staff removed the Immediate Jeopardy on 07/17/24 at 04:28 PM by implementing the following actions: 1. All nursing staff educated by the end of the day on 7/17/24. Education included: policies for pressure ulcer prevention, wound care-infection prevention, skin checks, and physician notification. 2. An audit of all skin assessments and ensured all wound assessments up to date as of 7/16/24. 3. Assistant Director of Nursing (ADON) named as person responsible for re-assessment of wounds weekly. The Director of Nursing (DON) will monitor for compliance. In the absence of the ADON, the DON will re-assess all wounds weekly. 4. A skin assessment will be completed by the admitting nurse on the day of admission. Any wound will be documented on the wound record. Skin will be observed by the bath aides at least weekly per the skin check policy. Any abnormalities will be reported to the charge nurse for assessment. Any new wound identified will be documented on the wound record. 5. Physician/provider will be notified of wounds present on admission, new wounds, and wounds not responding to treatment. Licensed nurse will call the provider if there is no response from the provider within 24 hours. DON and the ADON will monitor documentation to ensure compliance. 6. A copy of the facility's wound assessment will be sent with a resident for any wound clinic appointment. The scope lowered from J to G at the time of the survey. Findings include: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Admission Nursing Assessment, dated 5/28/24, revealed Resident #9 right heel noted to have an open area measuring 0.8 centimeters (cm) by 0.8cm. The Admission Assessment identified bruises on left hand, left lower leg, right lower leg, an open area on front of right lower leg, and intravenous infiltration site to the right antecubital (area on arm commonly used for IV insertion). Assessment lacked identification of pressure injuries. A Wound and Skin Healing Record, dated 5/28/24, identified a right heel Stage 2 pressure injury, measuring 0.8cm by 0.8cm with 0.1 cm depth. Assessment of the Stage 2 pressure injury revealed the wound bed had normal tissue, no drainage, no odor, no pain present, and surrounding skin had normal appearance. A Braden Assessment (used to identify risk of pressure ulcer development), completed 5/28/24, identified Resident #9 at moderate risk for development of pressure injuries due to occasionally moist skin, very limited mobility, inadequate nutrition, and problem with friction or skin shearing from moderate to maximal assistance required with movement. Additional Braden Assessments, completed on 6/25/24 and 7/05/24, continued to identify Resident #9 at risk for development of pressure injuries. A Nursing Progress Note on 5/28/24 at 3:57 PM, revealed Resident #9 had arrived to facility following a fall at home and left hip fracture that had an incision site with 15 staples in place and covered with foam dressing. Resident #9 noted to have aphasia (difficulty with speech) and right facial drop from past stroke. Nurse indicated skin assessment completed and Primary Care Provider (PCP) notified of skin issues. The Baseline Care Plan, completed on 5/29/24, identified skin break interventions that included pressure reducing mattress and skin/wound treatments to be found on the Medication/Treatment Administration Record. The Baseline Care plan lacked documentation of a pressure ulcer present on admission. A Nursing Progress Note, dated 5/31/24 at 9:27 PM, revealed Resident #9 right heel wound had a clean, dry dressing applied. Note lacked assessment, including measurements of the wound. The Minimum Data Set (MDS) assessment, dated 6/03/24, revealed Resident #9 required substantial to maximal staff assistance to transfer and partial to moderate staff assistance for bed mobility. The diagnoses listed for Resident #9 included: diabetes mellitus, cerebrovascular accident (CVA or Stroke), and heart failure, and an encounter for orthopedic aftercare. The assessment identified Resident #9 had a surgical wound and required a pressure reducing device for chair and bed, surgical wound care, the application of nonsurgical dressings, and ointment or medications applied (other than to feet). The Brief Interview for Mental Status (BIMS) result of 15 out of 15 indicated the resident had intact cognition. The MDS lacked identification of unhealed pressure injuries on admission, and did not identify the resident at risk for pressure ulcers. The Care Plan, revised on 7/03/24, indicated Resident #9 had been at risk for skin breakdown related to fractured hip, previous cerebrovascular accident, weakness, and pain, staff instructed to monitor and report signs of skin breakdown, and complete skin treatments as ordered. The Care Plan lacked identification of pressure injuries or unhealed skin impairments. The Medication Administration Record (MAR), dated May 2024, revealed the following orders: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Mepilex wound pad, started 5/29/24, to be placed to left leg topically every evening on Monday, Wednesday, and Friday, related to atherosclerotic heart disease of native coronary artery diagnosis. 2. Mupirocin Ointment 2%, started 5/29/24 and discontinued 6/11/24, to be applied to wound every evening shift on Monday, Wednesday, and Friday, for wound. A review of SNF (Skilled Nursing Facility) Documentation Fracture, from 5/29/24 to 6/18/24, lacked identification, assessment or monitoring of Resident #9's right heel Stage 2 pressure injury. A Nursing Progress Note, dated 6/05/24 at 4:10 AM, revealed Resident #9 called with complaint of pain to right heel, nurse noted an open area on right heel, and determined this area had been documented in the admission assessment. Nurse identified no treatment orders in place for right heel wound, faxed PCP for treatment orders, and floated Resident #9's heels. A Nursing Progress Note, dated 6/07/24 at 4:37 PM, revealed the PCP faxed back for Resident #9 to have a wound care consultation, appointment with Wound Clinic on 6/10/24. The Wound Office/Clinic Note, dated 6/11/24, lacked assessment or documentation of right heel Stage 2 pressure injury. Visit note revealed Resident #9 presented with Stage 3, bilateral pressure Injury to buttocks that measured 10cm by 6cm with 0.1cm depth. Discharge documentation included the following orders: 1. Treatment to buttocks to include an equal mixture of clotrimazole 1% cream, mupirocin 2% ointment, and triad barrier cream to buttocks twice per day. Do not scrub excess cream off, gently wipe away soiled cream and reapply. 2. Keep wounds out of shower water. 3. Reposition every 2 hours and place cushion in every chair. 4. Offer nutritional shake or protein ice cream with meals and at bedtime. A Wound and Skin Healing Record, dated 6/18/24, recorded an assessment of the Stage 2 pressure injury to right heel with measurements of 1.8cm by 2.4cm without depth, and a description of the wound bed as lacking educate (drainage), odor not assessed, wound bed normal, surrounding skin color and tissue normal. Response to treatment assessed as deteriorated. A handwritten note indicated fax sent to Dr. The Wound/Skin Healing Record, dated 6/18/24, revealed a Stage 2 pressure injury noted to left heel that measured 3.8cm by 3.4cm, had small amount of serosanguineous drainage, wound bed and surrounding skin documented as normal tissue. No Provider or family notification documented on healing record. No additional assessments or measurements documented for Stage 2 pressure injury of left heel. A Nursing Progress Note, dated 6/18/24 at 5:35 PM, revealed Resident #9 had an area of skin impairment to left heel that measured 3.8cm by 3.4cm and the right heel measured 1.8cm by 2.2cm. Nurse applied heel protector and faxed PCP with update and request for an order to apply Betadine twice a day to heels. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of SNF Documentation Fracture from 6/19/24 through 6/26/24, revealed Resident #9 had open areas to right lower extremity and bilateral heels, no assessment of wounds or measurements documented. The Wound/Skin Healing Record, dated 6/19/24, revealed identification of a blood blister to top of right first toe, document lacked wound measurement or assessment of tissue, the surrounding skin, or drainage type. Document indicated Provider and family had been notified of wound on 6/19/24. No additional assessments or measurements documented for blood blister to top of right first toe. A Nursing Progress Note, dated 6/19/24 at 10:57 AM, revealed Resident #9 had new area of skin concern on top of first toe, appeared to be a blood blister, that measured 0.4cm by 0.6cm. Nurse informed PCP that a foam dressing had been applied to area for protection and requested order to change padded dressing daily. A Nursing Progress Note, dated 6/20/24 at 01:42 AM, revealed an order received from PCP for foam border dressing, to be replaced every other day, to top of first toe for two weeks time. A Nursing Progress Note, dated 6/25/24 at 4:56 PM, indicated Resident #9 went to a Wound Clinic appointment and received new orders. The Wound Office/Clinic Note, dated 6/25/24, revealed Resident #9's husband had requested for Provider to inspect resident's feet, and upon removal of socks, Resident #9 noted to have multiple pressure injuries to bilateral feet. Visit Note indicated that the Nursing Facility had been called to obtain further information regarding wounds. Facility informed Wound Clinic they were aware of the right heel ulceration and first noted it on 6/21/24, but were unaware of any ulcerations to Resident #9's left foot. Assessment of Resident #9's right foot, during Wound Clinic visit on 6/25/24, revealed a large, oval shaped ulceration noted to the lateral aspect (side) of the right heel, which measured 1.5cm by 2cm. Right heel wound bed covered with moderately adhered cream colored slough (non-viable) tissue. Wound Clinic performed an excisional (scalpel) debridement of wound. Wound Clinic identified wound as a Stage 3 pressure injury. Assessment of Resident #9's left foot, during Wound Clinic visit on 6/25/24, revealed a large circular shaped ulceration noted to the posterior aspect of left heel, which measured 3.1cm by 3cm with 0.1 cm depth. Left heel wound bed covered with black, dry, eschar (dead) tissue. Wound Clinic identified left heel wound as an unstageable pressure injury. Assessment of Resident #9's buttocks, during Wound Clinic visit on 6/25/24, revealed redness and excoriation over bilateral buttocks with scattered ulcerations and satellite macules (similar to that of yeast infection). Buttocks ulcerations had granulated tissue to wound beds. Wound Clinic identified buttocks wound as Stage 3 pressure injury to bilateral buttocks. The Medication Administration Record (MAR), dated June 2024, revealed the following treatment orders: 1. Mepilex foam border dressing, started 6/20/24, to be applied to right first metatarsal topically one time a day, changed every other day, for 14 days. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Foam dressing to right lateral foot boney prominence's, started 6/26/24, to be applied every evening shift, every 3 days, for wound care. 3. Betadine Solution 10%, started on 6/26/24, to be applied to left heel topically every evening shift, every other day, for wound care. 4. Mupirocin 2% ointment and prisma, started on 6/26/24, to be applied to wound bed and covered with foam border every evening shift, changed every other day for wound care. 5. Mupirocin 2% ointment, started on 6/26/24, to be applied to right medial foot and left plantar foot, to be covered with foam border dressing and changed every other day for wound care. In a Nursing Progress Note, dated 6/27/24 at 11:18 PM, revealed dressings to bilateral feet had fallen off, feet were redressed with foam border dressing. Nurse noted left heel had dried brown drainage on old dressing and Resident #9 had reported pain with dressing change. Nurse charted that Resident #9's feet supported in boots and elevated on pillows following wound care, no indication of Provider or family notification. In a Nursing Progress Note, dated 7/05/24 at 10:34 AM, nurse reported Resident #9 had increased pain and cracking sensation in left knee, call placed and message left for Orthopedic Provider with request for any new orders. A Nursing Progress Note, dated 7/05/24 at 1:56 PM, revealed Resident #9 left facility with family to a Wound Clinic appointment. A Nursing Progress Note, dated 7/05/24 at 4:07 PM, revealed the facility had been notified by Wound Clinic that Resident #9 was sent to the Emergency Department (ED) for suspected cellulitis. Note indicated the Wound Clinic reported to facility that Resident #9 had a lot of redness and warmth by right foot wound. A Wound Office/Clinic Note, dated 7/05/24, revealed that upon evaluation, it is noted Resident #9's wounds had deteriorated significantly. Redness noted to right foot and left knee, present for an unknown length of time due to lack of documentation of it from facility. Wound Clinic Provider indicated a concern related to infection of the right foot that required further workup. Wound Clinic Provider discussed transfer to Emergency Department with Resident #9 and family whom stated understanding and agreement to further evaluation. Assessment of Resident #9's right foot, completed by Wound Clinic on 7/5/24, revealed irregularly shaped non-pressure ulceration noted to right medial foot that measured 2cm by 3.1cm with 0.1cm depth, wound bed had yellow slough and macerated (damage from moisture) tissue, copious amounts of seropurulent (containing pus) drainage, malodor, and significant redness, warmth, and edema surrounding wound. The right heel continued to have oval shaped Stage 3 pressure ulceration, that measured, 1.5cm by 2.3cm with 0.1cm depth, covered with cream colored slough tissue, moderate amount of serosanguineous drainage, and maceration of skin surrounding ulcer. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Assessment of Resident #9's left foot, completed by Wound Clinic on 7/5/24, revealed a large circular, Stage 3 pressure ulceration, noted to the left heel that measured, 4cm by 3.4cm with 0.1cm depth, wound bed covered with black, dry, eschar tissue. Assessment of Resident #9's buttocks/coccyx area, completed by Wound Clinic on 7/5/24, revealed redness and excoriation noted to the coccyx, that extended to the buttocks, and back of thighs with scattered ulcerations noted on bilateral buttocks, identified as a Stage 3 pressure injury of bilateral buttocks. A Nursing Progress Note, dated 7/05/24 at 5:27 PM, revealed a notification from the Hospital that Resident #9 had been admitted for sepsis related to left knee infection, a right foot infection, and poorly controlled Diabetes Mellitus. The Transfer Assessment, completed by facility on 7/05/24 at 8:14 PM, indicated Resident #9 had discharged to the hospital. Transfer Assessment lacked documentation of pressure injuries or unhealed skin impairments. The Hospital Emergency Department (ED) Note, dated 7/05/24 at 5:02 PM, revealed that Resident #9 had been sent from the Wound Clinic with bilateral foot redness and wounds. Resident #9 presented with left knee pain, small swelling of bilateral foot wounds, and poor control of diabetes. ED noted bilateral heel pressure sores with eschar in which debridement of tissue may be required. Redness and bruising noted over the right first toe, with possibility of cellulitis and indicated Resident #9 would need x-ray of bilateral feet, antibiotics, and possible admission for the same. ED Note revealed that Resident #9 had been given fluids, antibiotics, and insulin intravenously. The ED Note revealed the following assessment/plan: 1. Infection of left knee 2. Right foot infection 3. Poorly controlled type 2 Diabetes Mellitus 4. Sepsis (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/16/24 at 10:42 AM, Staff C, Registered Nurse (RN) confirmed she completed the admission skin assessment for Resident #9 on 5/28/24. Staff C recalled an open area on Resident #9's right heel on admission, that had been covered with a foam dressing, unable to recall how wound appeared during admission assessment. Staff C informed that Resident #9 had no treatment orders for the open area on right heel, stated she assessed the wound, re-applied foam dressing, and then faxed the Primary Care Provider (PCP) regarding the skin impairments noted in the admission assessment. Staff C unable to recall if PCP responded to fax. Staff C reported that evening shift nurse had been responsible for weekly monitoring and assessment of Resident #9 wounds as well as completion of treatment for Resident #9's heels. Staff C informed she had thought the heels were getting better. Staff C revealed that in Skilled Nursing Facility assessment documentation, open areas would be mentioned if known, but the assessment and measurement documentation would be completed on Wound/Healing Record. Staff C denied having seen Resident #9's feet the week she went to the hospital and denied changes noted in Resident #9's condition. Staff C informed that she would fax PCP with any new wounds observed, denied having called Resident #9's PCP with updates on her wounds. On 7/16/24 at 11:22 AM, Staff D, Licensed Practical Nurse (LPN), confirmed she had completed multiple daily SNF assessments on Resident #9. Staff D stated that open areas or skin issues would be mentioned in the daily assessments, as well as in Nursing Progress Notes. When asked why SNF assessments completed by Staff D had lacked information related to Resident #9's wounds, Staff D revealed she had not known about any of Resident #9's pressure injuries until survey. When asked how nurses would be informed about wounds, Staff D claimed there would be information on the MAR or Admission Assessment, in Progress Notes, and through verbal communication with other nurses. Staff D revealed first and second shift nurses each had a list on Tuesdays and Wednesdays which notified the residents due for a weekly skin assessment. Staff D recalled Resident #9 had been non-ambulatory, but worked with therapy on transfers, also stated Resident #9 had poor eating habits and required Provider notification related to blood sugar levels. On 7/16/24 at 11:45 AM, Staff E, Agency Staff Registered Nurse (RN), recalled Resident #9 had a couple pressure injuries located on heels, stated she had competed wound treatment the week prior to hospitalization and remembered that wounds had some drainage, but did not recall any signs of infection. Staff E informed she would know about wounds when treatment orders showed up on the MAR to be completed. Staff E unaware of facility's schedule for weekly skin assessments. On 7/16/24 at 12:02 PM, Staff F, Licensed Practical Nurse (LPN) confirmed she had worked with Resident #9 on 07/05/24. Staff F denied changes in Resident #9's condition when she left for Wound Clinic appointment and stated she had not seen Resident #9's feet that day because dressings and booties had been placed on feet. On 7/16/24 at 2:33 PM, Staff G, Licensed Practical Nurse (LPN), worked overnight shifts and recalled Resident #9 was not very alert or oriented. Staff G stated Resident #9 required repositioning every 2 hours, due to wound on her bottom, did not recall any other wounds present on Resident #9. Staff G did not recall heel protectors worn by Resident #9 overnight. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/16/24 at 2:43 PM, Facility Administrator provided a For Your Information (FYI) sheet completed by Staff C, RN, that reported admission skin assessment findings on Resident #9 with an order request for open areas on right heel and shin. A stamp at the top of document indicated that fax had been sent to PCP on 5/28/24. Facility unable to produce additional documentation of confirmation that fax had been sent or Provider response to fax. Administrator denied any follow up documentation related to admission skin assessment fax and revealed the expectation of nurses to call Provider within 24-48 hours if no response is received. On 7/16/24 at 3:00 PM, Staff H, Registered Nurse (RN), revealed she had worked Wednesday evenings during the months of May and June 2024. Staff H stated Resident #9 had wounds to right upper arm and one on her heel. Staff H denied Resident #9 having any wounds on buttocks. Staff H reported Resident #9's right heel had been pretty red and looked sore just before she was hospitalized , Staff H denied notification to Provider. Staff H revealed that skin sheets would be completed on admission and monitored weekly. Staff H revealed that the nurse working when the weekly wound assessments were due would be responsible for completing wound measurements and assessment. Staff H revealed that a wound assessment included measurements, how the wound looked, and if the Provider had been notified. Staff H identified times in which the Provider should be notified about wounds would be on admission, changes in wound conditions such as worsening, abnormal tissue or drainage and stated notification is faxed to Provider or, if needed to addressed that day, to call the Provider's office. On 7/17/24 at 1:00 PM, Staff I, Registered Nurse and MDS Coordinator revealed when residents are admitted , she would review the Admission Assessment and Nursing Progress Notes to determine if wounds were present on admission. Staff I revealed wounds and pressure injuries should be included in the Care Plan with indication of wound type and interventions. Staff I confirmed Resident #9's Care Plan lacked identification of pressure injuries or unhealed wounds. The facility provided a document, titled Weekly Skin Measurements, not dated, that revealed Resident #9 had been scheduled for wound measurements every Wednesday evening shift. The facility provided documents, titled Bathing Documentation and Skin Assessment, completed on Resident #9, by Certified Nursing Assistant (CNA) staff on the following dates: a. 5/31/24- Shower given, no skin issues identified. b. 6/04/24- Resident refused. c. 6/07/24- Resident refused. d. 6/14/24- Bed bath given, no skin issues identified. e. 6/18/24- Resident refused. f. 6/21/24- Resident refused. g. 6/25/24- Bed bath given, no skin issues identified. h. 6/28/24- Bed bath given, no skin issues identified. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	i. 7/02/24- Bed bath given, no skin issues identified. j. 7/05/24- Bed bath given, no skin issues identified. The facility policy titled, Pressure Ulcer Prevention Policy, not dated, revealed the facility shall have a system in place that assures assessments are timely and appropriate; interventions are implemented, monitored, and revised as appropriate; and changes in condition are recognized, evaluated, reported to the resident's attending practitioner and other healthcare professionals as appropriate. The policy informed that the facility shall provide, care, treatment, and services to promote the prevention of pressure ulcer development, promote healing of pressure ulcers that are present, and to prevent the development of additional pressure ulcers. The policy additionally revealed the following procedures nursing staff shall perform: 1. Assess, reassess, and document the ulcer's characteristics weekly. 2. Observe for infection. 3. Follow physician's orders for treatment of the pressure ulcer, including cleansing and dressing. 4. Monitor the healing process. 5. Assess, reassess, and manage the resident's pain. 6. Avoid positioning residents on a pressure ulcer. 7. Continue preventive measures to prevent other pressure ulcers from developing. 8. Observe and change dressings as ordered and needed. The Pressure Ulcer Prevention Policy further instructed that interventions shall be incorporated into the resident's plan of care, evaluated, and revised as the condition of the resident indicates. The facility policy titled, Skin Checks, dated 7/12/18, revealed that bath aides are to observe all resident's skin for abnormalities during each bath or shower, and report abnormalities to the charge nurse. The Skin Check policy instructed for charge nurse to complete an assessment of the skin and document on the appropriate skin assessment form. Policy further instructed charge nurse to notify physician and resident representative of any new or worsening area, obtain a treatment order as needed, and reassess skin impairments weekly. The facility policy titled, Physician Notification, dated 10/10/19, revealed that physician will be notified promptly for a significant change in resident condition which has potential for clinical complication with open skin listed in this category.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 45338 Based on observation, staff interview, and clinical record review the facility failed to ensure an antibiotic was initiated timely for treatment of a urinary tract infection (UTI) and failed to ensure clear process for frequency of urinary catheter change for one of one resident reviewed for catheters (Resident #45). The facility reported a census of 49 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment for Resident #45, dated 6/13/24, revealed the resident scored 4 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment the resident had an indwelling catheter and took an antibiotic. Review of the Care Plan for Resident #45, dated 4/11/24, revealed a Focus Area related to the Resident requiring an indwelling urinary catheter due to neurogenic bladder (lack of bladder control.). Interventions, all dated 4/11/24, included: a. Assess for continued need for catheter at least quarterly. b. Keep catheter system a closed system as much as possible. c. Obtain labs as ordered. d. Provide catheter care BID (twice a day) and PRN (as needed) e. Report UTI (acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain, difficulty urinating, low back/flank pain, malaise, n/v (nausea/vomiting), chills, fever, foul odor, concentrated urine, blood in urine). f. Use a catheter strap. Assure enough slack is left in the catheter between the meatus and the strap. Review of Physician Orders for Resident #45 revealed the following: a. (Order Start date 12/5/23, discontinued 5/21/24): Change catheter drainage bag every 2 weeks; once with entire system change. every day shift every 14 day(s) for infection prevention-catheter care. b. (Order start date 6/11/24, current order): Change catheter drainage bag every 2 weeks; once with entire system change. Every night shift starting on the 15th and ending on the 27th every month for infection prevention-catheter care (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record for Resident #45 revealed the resident's catheter changed on the following dates, as documented per clinical record review below: 1/15/24, 1/30/24, 2/4/24, 3/13/24, 3/29/24, 4/18/24, 5/5/24, and 6/28/24. Review of the Health Status Note dated 1/26/24 at 3:58 PM revealed, Sediment noted in tubing of Foley catheter. Sediment is pink tinged and thick. Urine is cloudy and dark in color. Draining as expected. Catheter was last changed on 1/15/2024. Sending this note to Dr. [Name Redacted], PCP (Primary Care Physician) to update on Foley. Handwritten under the note was the following: May we have an order for acetic acid flushes daily? Would you like a UA (urinalysis) collected? Resident is asymptomatic with stable vital signs. The following response written by an ARNP, and dated 1/30/24: order sent (change symbol) Foley [illegible word redacted] insert new Foley send clean urine for UA and C&S (culture and sensitivity) if indicated may need ID (infectious disease) if repeat UTIs. Review of the Physician Order dated 1/30/24 by an ARNP revealed, change Foley catheter. Obtaining urine sample from clean catheter drainage. Send for urinalysis with culture and sensitivity if indicated. Report to PCP abnormal vital signs, fever, or abdominal pain/pelvic pain or bloody urine. Review of the Orders-Administration Note dated 1/30/24 at 10:51 AM revealed, Change catheter and get a Cath ua with C&S w/reflux one time only for possible UTI until 01/30/2024 23:59 changed catheter via sterile technique, also collected a ua sent to [abbreviation for hospital name redacted]. Review of the Health Status Note dated 2/3/24 at 8:28 PM revealed, Res (resident) noted to have pink tinged urine in catheter tubing and bag. Did not change catheter due to irritation. Resident denies pain or discomfort coming from catheter. Will attempt to change catheter tomorrow. Review of the Health Status Note dated 2/4/24 at 7:17 AM revealed, Foley cath changed, 16 FR [16 french - catheter size] inserted times 1 attempt, clear yellow urine returned. Resident tolerated well. Review of the Orders-Administration Note dated 3/12/24 at 1:35 PM revealed, Change catheter drainage bag every 2 weeks; once with entire system change. Every day shift every 14 day(s) for infection prevention-catheter care will replace on 3/13/24 resident didn't want to lay down after lunch. Review of the Orders-Administration Note dated 3/13/24 at 2:04 PM revealed, in part, Changed this catheter and bag via sterile technique. Resident tolerated well. Review of the Communication with Physician Note dated 3/28/24 at 11:48 PM revealed, Res has been having increased confusion, Urine in Catheter bag is dark yellow, cloudy, and has a slight odor, She has been complaining of not feeling well, Staff is currently trying to push fluids. May we have an order for UA (urinalysis) with C&S (culture and sensitivity if needed. Further down on the note, a response of yes was given and signed by an Advanced Registered Nurse Practitioner (ARNP). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Health Status Note dated 3/29/24 at 9:30 PM revealed, The res urine was obtained per her order for UA C&S c (with) reflex. The urine has been delivered to the ER (emergency room) Lab at [name redacted] located nearest the facility. The res also had a catheter and urinary bag change, the catheter was changed to a 16 FR with 10cc (cubic centimeter) inserted. It is patent and the res tolerated well. Review of the Orders-Administration Note dated 4/18/24 at 1:14 PM revealed, in part, changed catheter and bag via sterile technique. Review of the Orders-Administration Note dated 4/23/24 at 11:53 AM revealed, in part, The entire system was change on 4/18/24, next time to change the bag would be two weeks and that would be 5/2/24. Review of the Health Status Note 5/5/24 at 7:13 AM revealed, Due to be changed,Catheter was changed via sterile technique w/16 FR catheter and bag. Review of the clinical record regarding initiation of antibiotics for UTI revealed, in part, the following: The Health Status Note dated 3/29/24 at 9:30 PM revealed, The res urine was obtained per her order for UA C&S c (with) reflex. The urine has been delivered to the ER (emergency room) Lab at [name redacted] located nearest the facility. The Physician Order present in the resident's paper chart electronically signed by an ARNP on 4/2/24 at 12:26 PM revealed, Levofloxacin 500 mg (milligram) PO (per oral) x1 dose on day 1; then decrease dose to 250mg (milligram) PO daily on day 2 through 5. The Physician Order further revealed the following: dose and abx (antibiotics) per C&S results and renal function, 80-90,000 cfu/ml (colony forming unit per milliliter) Pseudomonas aeruginosa, 60-70,000 cfu/ml Enterobacter cloacae complex, 80-90,000 cfu/ml Enterococcus faecalis, and 80-90,000 cfu/ml Lactobacillus species. Review of the resident's Medication Administration Record (MAR) dated 4/4/24 revealed Levofloxacin 500 mg (milligram), an antibiotic medication, administered to the resident on 4/4/24, and 250mg of the medication administered 5/5/4 through 5/8/24. On 7/11/24 at 8:13 AM, Resident #45 observed present in the dining room at the table. Resident #45 seated in a wheelchair at the table, and the resident had catheter tubing to dignity bag under the resident's wheelchair. On 7/11/24 at 12:12 PM, the MDS Coordinator explained would be in their orders, and changed monthly unless the doctor wanted more frequently for a Foley, and then PRN (as needed). During an interview on 7/11/24 at 1:34 PM, the Corporate Nurse explained the facility would use the physician order for frequency of changes, and further explained policy did not address how frequently to change. The Corporate Nurse explained they would have to see order in the resident's chart. When shown the order and queried how frequently the catheter would be changed, the Corporate Nurse acknowledged it was confusing.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45338 Based on clinical record review, staff interview, and facility policy review, the facility failed to ensure medications including a diuretic, antibiotic, and blood pressure medication were available from the pharmacy to administer to a resident for one of three resident reviewed for medication availability (Resident #45). The facility reported a census of 49 residents. Findings include: Review of the Minimum Data Set (MDS) assessment for Resident #45, dated 6/13/24, revealed the resident scored 4 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Review of Orders-Administration Notes dated 7/1/24 at 8:39 AM revealed the following medications documented as meds not delivered from pharmacy: Furosemide Oral Tablet 20 MG (milligram), a diuretic medication, with directions to give 0.5 tablet one time a day, Lisinopril Oral Tablet 40 MG with directions to give 1 tablet by mouth one time a day, Cephalexin Oral Tablet 250 MG, an antibiotic medication, with directions to give 1 tablet by mouth one time a day for prophylactic, Amlodipine Besylate Oral Tablet 10 MG with directions to give 1 tablet one time a day, and Alendronate Sodium Oral Tablet 10 mg with directions to give 1 tablet by mouth one time a day. Review of the Heatlh Status Note dated 7/1/24 at 11:03 AM revealed, Resident did not have any medications today d/t (due to) not arriving from [Pharmacy Name Redacted] at [Hospital Name Redacted] Call placed to pharmacy spoke with a [name redacted] she said we will send those out today. This note sent to PCP (Primary Care Physician). Review of the resident's Medication Administration Record (MAR) dated July 2024 revealed the resident's medications for 7/1/24 marked with a code of 9, which indicated other/see progress notes. On 7/11/24 at 12:10 PM during an interview with the MDS Coordinator, the MDS Coordinator acknowledged a concern with getting medications promptly for a new admission. On 7/11/24 at 1:35 PM during an interview with the Administrator and the Corporate Nurse, the following was explained: Typically what done was placed call to Resident #45's family or to the pharmacy directly to put in order to resend (medications). Review of the Facility Policy titled Medication Administration, dated 10/10/19 and revised 4/1/23, revealed the following: Medications shall be administered per physician order.