STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525454	A. Building B. Wing	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Health Services	2512 New Pine Dr Altoona, WI 54720

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47657 Based on interviews and record review, the facility did not ensure 1 of 3 residents (R2) were provided care and services to promote regular bowel movements (BM) that are in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs. Findings include: The facility stated they did not have a policy or procedure on bowel management. R2 was admitted to facility from a hospital 06/18/24 to 06/22/24, with a diagnosis of compression fracture of T9-T10 vertebra and history of constipation. R2's last known BM was 06/16/24 and did not have a BM during admission to facility. R2's Minimum Data Set (MDS), dated [DATE], indicated that R2 had a BIMS of 13 (cognitively intact), dependent on staff for toileting and chair/bed transfer. MDS was marked not applicable for toilet transfers. R2 was ordered and received MiraLAX 17 grams mixed with 8 ounces of water daily for constipation. R2 was ordered and received Senna Plus 2 tablets at bedtime for constipation. R2 was ordered and received Furosemide 40 mg one time daily (a diuretic that helps body get rid of extra fluid). R2 was ordered and received 4 doses of Oxycodone HCL 5mg as needed for pain (an opioid which slows down the movement of stool) during admission to facility. R2's base line care plan, dated 06/18/24, indicated last known BM was on 06/16/24. R2's care plan, dated 06/19/24, stated: Opioid use r/t vertebral compression fracture with a goal to not experience prolonged constipation, ileus, or impaction while taking opioids. Interventions include to monitor bowel habits and implement bowel regimen as ordered. On 06/20/24, standing orders were signed by provider that include: (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Milk of Magnesia (MOM) 30 cc 1x every other day for constipation. Bisacodyl 10mg suppository rectally 2x daily as needed for constipation. Fleets enema 2x weekly rectally as needed for constipation. On 06/19/24 at 1:20 PM, nurses notes state in part .Bowel patterns: regular elimination - 1 BM every 1-2 days On 06/21/24 at 11:12 AM, nurses notes state in part .[R2] explained that he felt constipated, like he had not had a decent BM in weeks. An enema was ordered but R2 was concerned about not being able to stand and move to the restroom or commode. R2 was offered a bed pan and refused this option. RN offered another dose of MOM and a suppository. R2 stated would rather try those options. On 06/22/24 at 1:41 PM, nurses notes state in part .Bowel incontinence: No bowel activity. Bowel patterns: subject to constipation-BM every 2-3 days, uses laxatives, suppositories, enema. On 06/22/24 at 4:22 PM, nurses notes state that R2's daughter requested transfer to hospital due to not having a BM for 4 days. On 07/08/24, Surveyor reviewed R2's medical record which shows no documentation of R2 having a bowel movement during admission from 06/18/24 to transfer to hospital on 06/22/24. On 07/08/24, Surveyor reviewed R2's medical record and was unable to locate a bowel assessment completed by facility to gather information of last bowel movement, usual elimination pattern, bowel sounds, palpation for distention, hydration status or recommendations and medications. On 07/08/24 at 11:30 AM, Surveyor reviewed R2's medication administration record which shows no documentation of R2 receiving MOM, enema, or suppository during the entire stay at facility from 06/18/24 to transfer to hospital on 06/22/24. On 07/08/24 at 2:32 PM, Surveyor interviewed Director of Nursing (DON) B and Registered Nurse (RN) C, who confirmed there was no policy, assessment or documentation to support that R2 received the as needed MOM, enema or a suppository and the expectation would be for nurses to provide MOM and/or prune juice and if no BM by next day to give a suppository. On 07/08/24, DON B and RN C confirmed there was no formal bowel assessment completed by facility. On 07/09/24 at 7:59 AM, Surveyor interviewed MD E who stated the expectation would be to call if complications of pain, nausea or vomiting or fever and would have expected facility would have provided MOM and suppository as documented or offered other laxatives for the constipation.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47657 Based on interviews and record reviews, the facility did not calculate 1 of 3 sampled residents' (R2) fluid intakes who are at high risk for dehydration, in order to determine if meeting a sufficient fluid intake to maintain or improve proper hydration and health. This is evidenced by: The facility policy, entitled Hydration, dated 07/26/22 states, The facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health. Sufficient fluid means the amount of fluid needed to prevent dehydration (output of fluids far exceeds fluid intake: and maintain health. The amount needed is specific for each resident and fluctuates as the resident's condition fluctuates (i.e., increase fluids if resident has fever or diarrhea). Both the American Medical Director Association and the American Dietary Association Guidelines recommend a minimum fluid intake of 1500 cc's (cubic centiliters)/day for adults regardless of body weight. This is based on a healthy adult. Some individuals may need additional fluids based on health conditions. These minimum calculations are taken by calculating 30 ml/kg (milliliters/kilogram) of the resident's weight. 30 ml is equal to one ounce. R2 was admitted to facility 06/18/24 to 06/22/24, with a diagnosis of compression fracture of T9-T10 vertebra and history of constipation. R2 was ordered and received Furosemide 40 mg one time daily (a diuretic that helps body get rid of extra fluid). R2's Minimum Data Set (MDS), dated [DATE], indicated that R2 had a BIMS of 13 (cognitively intact), dependent on staff for toileting and chair/bed transfer. MDS was marked not applicable for toilet transfers. R2'2 MDS dated [DATE] section J1550 indicates no dehydration. R2's care plan, dated 06/19/24, indicated at risk for nutritional status related to pain but does not address fluid needs. R2's dehydration risk assessment completed by facility, dated 06/29/24, indicated R2 had predisposing factors of medical history and medication that would place at risk for hydration. The assessment did not include fluid intake recommendations. A hydration risk care plan was not developed. On 07/08/24, Surveyor reviewed R2's documentation of R2 receiving daily fluid intakes of: 06/18/24 = 480 cc 06/19/24 = 1060 cc (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/20/24 = 520 cc 06/21/24 = 700 cc 06/22/24 = 240 cc On 07/08/24 at 1:43 PM, Surveyor interviewed Director of Nursing (DON) B and Registered Nurse (RN) C requested documentation to support facility assessed fluid intake to assure R2 was taking at a minimum the recommended 1500 cc of fluids daily to prevent dehydration. Both DON B and RN C confirmed not having assessments completed to monitor for dehydration and recommended fluid intakes. On 07/09/24 at 9:29 AM, Surveyor interviewed Dietary Manager (DM) D, who stated assessments are usually completed within 7 days but has up to 14 days to complete. DM D stated an assessment was not completed on R2's nutritional /fluid needs but reviewing chart would have recommended 2100 - 2500 cc of fluids daily.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on interview and record review, the facility did not establish an Infection Control Program under which it investigates, controls, and prevents infections in the facility, and a system for recording incidents identified under the facility's Infection Control Program, including corrective action in a timely manner, for both residents and staff. This has the potential to affect all 51 residents in the facility. The facility did not have a tracking program in place for the early detection of infected and exposed residents (R) and staff for scabies. Multiple nursing staff members worked when they had scabies and were being treated, then worked on multiple other resident units, thus exposing other residents to scabies. The facility did not have a tracking program in place for the early detection of exposed residents on these other units. This is evidenced by: According to the Centers for Disease Control and Prevention (CDC) standard of practice, .suggestions for developing guidelines for preventing, detecting, and responding to multiple cases of non-crusted scabies in an institution. Surveillance .Have an active program for early detection of infested patients and staff. Maintain a high index of suspicion that scabies may be the cause of undiagnosed skin rash; suspected cases should be evaluated and confirmed by obtaining skin scrapings . Control [and] Treatment .Maintain records with patient name, age, sex, room number, roommate(s) name(s), skin scraping status and result(s), and name(s) of all staff who provided hands-on care to the patient before implementation of infection control measures: symptoms can take up to 2 months to appear in exposed persons and staff .Identify and treat all persons (e.g. staff .patients, etc.) having prolonged, direct skin-to-skin contact with an infected person before he/she was treated CDC (2023, December 23) Single Case. Retrieved from https://www.cdc.gov/scabies/php/public-health-strategy-crusted/index.html On 07/08/24, the following number of residents resided on each facility units and halls: -Aspen unit: A hall-twenty-three residents -[NAME] unit: B hall-six residents -Cedar unit: C hall-twenty-two residents On 07/08/24 at 9:47 a.m., Surveyor received and reviewed the facility timeline for a current scabies (a condition caused by tiny insects, or mites, which infest and irritate the skin) outbreak amongst staff and residents. The timeline indicates: -Certified Nursing Assistant (CNA) F had symptoms of abdominal rash with no onset date documented of when the symptoms occurred but then was evaluated on 06/07/24 and started scabicide (Permethrin cream) on 06/12/24. CNA F worked on Aspen Hall. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Resident (R) R8 located on Cedar Hall had symptoms of right upper quadrant rash with onset date of 06/09/24. R8 was not placed on contact precautions until 06/23/24 and then began scabicide (Permethrin cream) on 06/25/24. -CNA G had onset symptoms of abdominal rash on 06/08/24 and was evaluated by a physician in urgent care which then CNA G was prescribed to start scabicide (Permethrin cream) on 06/11/24. CNA G worked on Aspen Hall. - CNA H had onset symptoms of arms and chest rash on 05/15/24 approximately and was evaluated by a physician in urgent care which then CNA H was prescribed to start scabicide (Permethrin cream) on 06/19/24 and 06/26/24. CNA H worked on Aspen Hall. - Registered Nurse (RN) I had onset symptoms of arm rash bilaterally on 06/12/24 and was evaluated by a physician which then RN I was prescribed to start scabicide (Permethrin cream) on 06/12/24. RN I worked on Aspen Hall. - CNA J had onset symptoms of abdominal rash on 06/16/24 and was evaluated by a physician on 06/16/24 in which then CNA J was prescribed to start scabicide (Permethrin cream) on 06/16/24. CNA J worked on Aspen, [NAME], and Cedar Hall. -R9 located on Aspen Hall had symptoms of a rash on hands with onset date of 06/17/24, scrapings were ordered that resulted in a positive result for scabies placed on contact precautions, and then began scabicide (Permethrin cream) on 06/17/24. -From 06/17/24-06/26/24, 14 more residents R3, R4, R5, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, and R20 became infected with scabies and was placed on contact precautions and scabicide (Permethrin cream). Review of the outbreak timeline did not indicate when any of the staff or residents' contact precautions ended. There is no documentation of skin scraping to test for scabies and why the test was not completed. Surveyor reviewed a note from MDS (Minimum Data Set) Coordinator C dated 06/12/24 that indicated that staff brought concerns to administration's attention in regard to rashes on Aspen Hall. Director of Nursing (DON) B and Assistant Director of Nursing (ADON) K began a full body review on 06/12/24 at 10:00 a.m. of all current residents on Aspen Hall. There was no documentation that [NAME] and Cedar Hall were assessed for skin rashes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/08/24 at 12:51 p.m., Surveyor interviewed Nursing Home Administrator (NHA) A and Director of Nursing (DON) B and asked about CNA F and CNA G reporting to DON B that CNA F and CNA G had scabies. DON B indicated that CNA F and CNA G came forward and reported to DON B that they had scabies. DON B indicated that DON B didn't think the staff members were positive for scabies as it was not brought to DON B's attention until after the fact, so DON B did not do anything about the staff members reporting the scabies infection amongst the two staff members. DON B indicated that DON B only knew about 2 of the 6 staff members on the line list that possibly had scabies until after it was too late. Surveyor asked NHA A and DON B when NHA A and DON B calculated that start of the scabies outbreak. DON B indicated the outbreak started on 06/20/24. NHA A indicated that NHA A started calling employee list to surveillance the scabies outbreak on 06/21/24. DON B indicated that through calling down the employee list four more staff members came forward and reported staff members had a scabies outbreak. DON B indicated that the four staff members had worked on all three halls throughout the facility but it was too late to try and mitigate scabies from spreading as it was after the outbreak was deemed active that the staff members came forward. On 07/08/24 at 2:52 p.m., Surveyor interviewed DON B and asked about scrapings category on the line list and why some of the residents were not tested for scraping results. DON B indicated that it was the choice of the physicians, and they did not want scrapings completed and to treat residents as rash presents. Surveyor asked DON B why skin assessments were not completed for [NAME] Hall and Cedar Hall after a resident down Cedar Hall had symptomatic rash down Cedar Hall and staff members that became symptomatic shortly after. DON B indicated the first 3 staff members only worked down Aspen Hall and the facility didn't think the facility needed to assess other halls. DON B indicated that staff should have performed skin sweeps on [NAME] and Cedar Hall along with Aspen Hall. Surveyor asked if the 3 staff members also float to dining room and help with feeding and delivery of trays. DON B indicated that yes, all staff members float to dining room, and activities area. On 07/09/24 at 8:16 a.m., Surveyor interviewed DON B and asked what conditions/diseases staff are required to report to DON B and Infection Preventionist (IP) once staff members become ill. DON B handed Surveyor the Employees Notice of Reportable Conditions. Surveyor reviewed and the list included: -#7 Scabies, - #9 Skin rashes, poison ivy/oak, impetigo, or staph. DON B indicated that all staff are trained on hire at orientation about the proper conditions and diseases that are reportable to administration to mitigate the spread of infections. DON B indicated that 4 of the 6 staff members did not report the staff's rashes until it was too late. .Concurrent treatment of contacts [i.e. staff] and individuals diagnosed with scabies is important, as the onset of symptoms is often delayed and therefore contacts may have active scabies while they are asymptomatic of pruritus. Family members that co-habit, including domestic workers, nurses, social workers, volunteers, therapists, assistants .and visitors .Identified contacts should be treated with the same regimen used for classic scabies .Restriction of staff rotation in the care facility has been identified as one of the steps of the successful control of outbreaks .Nurses who are caring for symptomatic patients and residents in the same ward are required to examine themselves regularly . Ong, C. & Fakhrudin, F. (2018) Infected with Scabies Again? Focus in Management in Long-Term Care Facilities. doi: 10.3390/diseases7010003. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	There were no resident line lists, to monitor for rashes or signs and symptoms of scabies, for the [NAME] and Cedar Halls, who were potentially exposed to scabies by nursing staff. There were no skin assessments to identify if rashes were present for the residents on [NAME] and Cedar Halls, after R8 who resides on Cedar Hall was found to have a rash on upper quadrant began, on or after 06/09/24. The facility did not actively treat all exposed residents on Aspen Hall, [NAME] Hall, and or on Cedar Hall when the facility knew they had scabies in staff members on 06/11/24. There were three residents (R8, R18, and R19) on Cedar Hall who became infected with scabies after the initial outbreak began. Facility had staff that did not report scabies infection to proper administration to mitigate the spread of scabies infection.