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	08/26/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46694 Based on interview and record review, the facility failed to notify resident's physician about a change in condition for 1 of 4 sampled residents (R)1. The facility did not inform physician about a deep tissue injury and change in vital signs for R1. Findings: The facility's policy titled, Change in Condition of the Resident, revised 09/20/2022, states in part: . When a resident presents with a possible change of condition, after a fall or other possible trauma, or noted changes in mental or physical functioning: 1. Assess the resident's need for immediate care/medical attention. Provide emergency care as needed. 2. Assess/evaluate the resident. This assessment/evaluation could include, but is not limited to the following: a. Vital signs . R1 was admitted to the facility on [DATE] with a Brief Interview of Mental Status (BIMS) of 11 which indicated a moderate impaired cognition, from an acute care hospital with diagnoses of malnutrition, multiple myeloma (also known as Kahler's disease, is an uncommon blood cancer that affects the bone marrow, the body's blood-forming system), left hip fracture of iliac wing (to heal with conservative measures), pain control, and therapy for a resident that was Non Weight Bear to the Left Lower Extremity (NWBLLE). Record review identified a Braden Scale (a standardized, evidence-based assessment tool commonly used in health care to assess and document a client's risk for developing pressure injuries) was completed on 05/20/24 at 4:53 PM, with a score of 21, which meant R1 was not at risk for skin breakdown. A weekly skin assessment was completed on 05/20/24 at 9:09 PM, which indicated R1 had a pressure injury to coccyx - from coccyx to peri area is dark purple and appears to be a Deep Tissue Injury (DTI). No open area noted. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor was unable to find any documentation in R1's medical record showing a physician was notified of this suspected DTI. R1 developed tachycardia (a rapid heart rate) starting on 05/25/24 at 5:43 PM with a reading of 100 beats per minute. On 05/26/24 at 2:07 AM, R1 had a heart rate of 105, at 7:08 AM, 124, at 6:30 PM, 100. On 05/27/24 at 3:55 AM, R1's heart rate was 122, and at 6:44 AM, 148. R1's blood pressure dropped to 92/58 on 05/26/24. There was no documentation of physician notification when abnormal blood pressure and heart rates were noted. Both of the changes are possible signs of sepsis. A daily skilled note, dated 05/26/24 at 6:02 PM, identified the following statement in part, .Resident reported concern about her heart and on auscultation she is regular despite tachycardia. Surveyor unable to identify information about how or why R1 was sent to the hospital and requested documentation. DON B provided Surveyor with the Situation, Background, Assessment, and Recommendation (SBAR) and transfer to hospital form. On 05/27/24 at 7:32 AM, the SBAR communication form reads in part: . BP 122/65, Pulse 148, RR 18, temp, 98.1, Skin evaluation: Pressure ulcer Does the patient have pain: Yes the pain is new Description of pain/location: New wound measuring at 3.7 x 2.2 x 0.7 with foul smelling purulent drainage noted coccyx. Intensity: 6 Called on call for [hospital] and spoke with [Medical Doctor (MD) G] who gave orders to send to ER for evaluation and treatment. R1's Daughter notified 05/27/24 at 7:32 AM. On 05/27/24 at 8:15 AM, the ambulance record states the staff reports that R1 had been feeling unwell, complaining of fatigue, lower back pain and fevers for the past two days. Staff checked a pressure ulcer located on the patient's coccyx and stated that it was black and oozing. Staff report the patient had a low-grade fever yesterday of 100 degrees F. Ambulance record indicates temperature of 99.5, HR of 136, 120, BP stable. On 08/21/24 at 8:50 AM, Surveyor interviewed via phone MD G regarding R1's care to the pressure injury. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/24 at 9:08 AM, Surveyor asked MD G via phone if MD G was informed of the DTI to R1's bottom. MD G indicated the first time MD G was notified was when the facility requested to send R1 to the emergency roiagnom on [DATE]. Surveyor asked MD G if staff notified MD G with any change of condition related to elevated heart rate on 05/25/24 and noted decreased blood pressures. MD G indicated did not see anything documented for notification of this.

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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 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** 46694 Based on observation, interview, and record review, the facility did not ensure each resident receives cares consistent with professional standards of practice to prevent pressure injuries (PIs) for 2 of 4 sampled residents (R)1 and R3. On admission 5/20/24, staff identified R1 had a suspected deep tissue injury (DTI) from the coccyx to the peri area. Physician, Director of Nursing, or wound nurse were not notified of this suspected DTI. No care plan or interventions were put in place for the pressure injury. Pressure injury assessments were not completed after the identification of the DTI on 5/20/24. As a result, R1 developed an unstageable pressure injury and sepsis. R1 required hospitalization and surgical debridement of the PI. The PI was staged as a stage 4 pressure injury. The facility's failure to implement pressure injury interventions and assess R1's pressure injury, created a finding of immediate jeopardy that began on 05/27/24. Nursing Home Administrator (NHA) A, Director of Nursing (DON) B and [NAME] President of Success (VPS) J were notified of the immediate jeopardy on 08/21/24 at 12:16 PM. The immediate jeopardy was removed on 8/21/24; however, the deficient practice continues at a scope/severity level of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan and as evidenced by the following example: R3 was admitted to the facility 08/09/24 with a PI on the left heel. R3's care plan included float heels as able; use pillows and/or positioning devices as needed. R3's heels were not being floated during numerous observations by survey team. Example 1: Based on the National Pressure Injury Advisory Panel (NPIAP), Pressure Injury Prevention Points dated April 2016, stated in part, RISK ASSESSMENT .5 Develop a plan of care based on the areas of risk, rather than on the total risk assessment score .SKIN CARE 1 Inspect all of the skin upon admission as soon as possible 2 Inspect the skin at least daily for signs of pressure injury, especially nonblanchable erythema. 3 Assess pressure points, such as the sacrum, coccyx, buttocks, heels, ischium, trochanters, elbows, and beneath medical devices. 4 When inspecting darkly pigmented skin, look for changes in skin tone, skin temperature and tissue consistency compared to adjacent skin . 8 Avoid positioning an individual on an area of erythema or pressure injury .REPOSITIONING AND MOBILIZATION . 5 Avoid positioning the individual on body areas with pressure injury. R1 was admitted to the facility on [DATE] from an acute care hospital. R1 had a documented Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. R1 has diagnoses of malnutrition, multiple myeloma (also known as Kahler's disease, an uncommon blood cancer that affects the bone marrow, the body's blood-forming system), left hip fracture of iliac wing (to heal with conservative measures), pain control, and therapy for non-weight bearing to the left lower extremity (NWBLLE). R1's Minimum Data Sets (MDS) assessment, dated 05/27/24, included the following: Mobility: (continued on next page)

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Partial/moderate assistance with roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, tub/shower transfer. Substantial/maximal assistance with toilet transfer. Skin: Does resident have a pressure injury: No Is resident at risk of a pressure injury: Yes Pressure reducing device for chair and bed: Yes Turning/Repositioning: No Pressure ulcer care: No Application of nonsurgical dressing: No On 8/20/24 at 11:00 AM, Surveyor reviewed R1's CNA Kardex (patient care summary). The Kardex indicated R1 was assist of 1 with bed mobility, personal hygiene, toileting bathing and showering. Transfer assist of one with gait belt. Record review identified a Braden Scale (a standardized, evidence-based assessment tool commonly used in health care to assess and document a client's risk for developing pressure injuries) was completed on 05/20/24 at 4:53 PM, with a score of 21, which meant R1 was not at risk for skin breakdown. Of note, R1 needs assistance to roll left and right, and partial to moderate assistance for all transfers. A weekly skin assessment completed on 05/20/24, at 9:09 PM, indicated R1 had a pressure injury to coccyx, From coccyx to peri area is dark purple and appears to be a DTI. No open area noted. Surveyor was unable to find any documentation in R1's medical record showing a physician, the wound care nurse or the DON was notified of this suspected DTI. Further review of R1's medical record identified there was no care plan for actual skin breakdown. R1 had a care plan focus, stating, At risk for alteration in skin integrity related to: impaired mobility. Interventions for this care plan included: Barrier cream to peri area/buttocks as needed, diet and supplements per Medical Doctor (MD) orders, observe skin condition with Activities of Daily Living (ADL) care daily and report abnormalities. The skin integrity care plan did not include any individualized pressure interventions for R1's coccyx DTI. There was no turning schedule despite R1 needing partial/moderate assistance with turning. Doctor's orders: NWB LLE started 05/20/24. Complete initial skin assessment and document in point click care every shift. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Weekly skin review every Wednesday start 05/22/24 revision date 05/20/24. On 5/26/24, there was a weekly skin review in the medical chart, with a box checked for bruises under the skin conditions section. Nothing is documented under the site or description sections of the document. This weekly skin review has no documentation on the coccyx DTI. On 5/27/24 at 5:29 PM, the next progress note states in part: .Daughter came up to desk at shift change and stated that [R1] was admitted to the hospital for surgical procedure on her buttock. Surveyor was unable to identify information about how or why R1 was sent to the hospital in the medical record. Surveyor requested documentation. Director of Nursing (DON) B provided Surveyor with the Situation, Background, Assessment, and Recommendation (SBAR) and transfer to hospital form. The SBAR communication form reads in part on 05/27/24 at 7:32 AM: .BP 122/65, Pulse 148, RR 18, temp, 98.1, Skin evaluation: Pressure ulcer Does the patient have pain: Yes the pain is new Description of pain/location: New wound measuring at 3.7 x 2.2 x 0.7 with foul smelling purulent drainage noted coccyx. Intensity: 6 Called on call physician for acute care hospital and spoke with Medical Doctor (MD) G who gave orders to send to ER for evaluation and treatment. R1's Daughter notified 05/27/24 at 7:32 AM. Surveyor reviewed the ambulance report. On 05/27/24 at 8:15 AM, the ambulance record states the staff report that R1 had been feeling unwell, complaining of fatigue, lower back pain and fevers for the past two days. Staff checked a pressure ulcer located on the patient's coccyx and stated that it was black and oozing. Staff report the patient had a low-grade fever yesterday of 100 degrees Fahrenheit. Ambulance record indicates temperature of 99.5, HR of 136, 120, BP stable. On 08/20/24 at 9:48 AM, Surveyor phone interviewed R1's family member for any new or pertinent information. R1's daughter informed Surveyor that R1 required surgery for the wound on the butt, and the acute care facility that did the surgery staged the wound as a stage 4 pressure injury. R1 was still in another nursing home. R1 has not been home for 3 months now and her cancer treatments were put on hold until the wound could heal. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/20/24 at 12:45 PM, Surveyor interviewed Certified Nursing Assistant (CNA) D regarding cares for R1. CNA D did recall caring for R1. CNA D did not recall being informed that R1 had any skin issue or wounds at the time of admission to the facility. CNA D did not recall that R1 had any special turning or repositioning plan. CNA D did recall that R1 had a standard bed mattress and a cushion in the wheelchair. CNA D remembered one day, but was unsure of which day, when caring for R1 there was drainage from R1's bottom and on R1's depends. CNA D noted redness on R1's bottom and called Registered Nurse (RN) E to assess R1's skin. CNA D does not remember what or if any new interventions were started after this observation of redness and drainage. On 08/20/24 at 2:27 PM, Surveyor asked Assistant Director of Nursing (ADON) C (the facility's wound nurse), about the process of being notified if a resident has a PI. ADON C indicated on admission to the facility, if a resident has a PI, staff open up a wound tracker and that triggers ADON C to look at it on wound rounds on Wednesdays. On 08/20/24 at 2:40 PM, Surveyor interviewed Registered Nurse (RN) E. Surveyor asked RN E about being called in to assess an open wound on R1. RN E indicated the original wound was red and wasn't open, so barrier cream was applied and no dressings were in place at that time. RN E did not think that it needed any further treatment because it was red and not open. RN E indicates she would have notified the wound nurse if the area was open. Surveyor could not find any documentation in R1's medical record identifying RN E's assessment of the redness and drainage that was reported by CNA D. On 08/20/24 at 3:59 PM, Surveyor interviewed RN F regarding pressure relieving devices for R1. RN F indicated that R1 had a pressure relieving chair cushion in the wheelchair, and the facility provides those for all residents' wheelchairs. R1's mattress was a standard mattress. RN F also indicated that R1 was not started on a turning or repositioning schedule. RN F informed Surveyor that every time R1 went to the bathroom skin barrier cream was applied to the purple area and this area remained intact until R1 went to the hospital. RN F was asked about assessments that were performed on this area. RN F informed Surveyor that CNAs saw R1's bottom every time they took R1 to the bathroom and they never reported any open areas. On 08/21/24 at 8:50 AM, Surveyor interviewed via phone Medical Doctor (MD) G regarding care for R1's pressure injury. MD G informed Surveyor there was a hospital follow up visit completed on May 23, 2024, and there was no mention of or complaints of any skin issues. MD G informed Surveyor R1 did not complain of skin issues at the time of admission. Surveyor asked MD G if MD G was informed of the DTI to R1's bottom. MD G indicated, the first time I was notified was when the facility was sending R1 to the emergency roiagnom on [DATE]. On 08/21/24 at 10:21 AM, Surveyor interviewed ADON C about the suspected DTI to R1's bottom on admission. ADON C denied knowing anything about it. ADON C informed Surveyor that ADON C was never notified of the DTI. On 08/21/24 at 10:32 AM, Surveyor asked DON B about the suspected DTI to R1's bottom on admission. DON B informed Surveyor that DON B was never made aware of the DTI on 5/20/24. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The failure to ensure each resident receives cares consistent with professional standards of practice to prevent pressure injuries created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy that began on 05/27/24. On 08/21/24, the facility took steps to correct the deficient practice and ensure compliance. The immediate jeopardy was removed on 08/21/24 when the facility implemented the following: 1. Facility in-house residents had their skin inspected by RN on 08/21/24 and no unidentified pressure injuries were discovered, current interventions were reviewed and verified in place as per care plan, and treatment orders are in place, accurate, and completed as ordered as of 08/21/24. 2. Re-education to licensed nursing staff (RNs and LPNs) was initiated on 08/21/24 for aggressive pressure injury prevention including visually inspecting resident's skin upon admission or readmission to identify skin impairments, notifying physician to obtain orders for treatment, notifying responsible party of resident, and interdisciplinary team (IDT) re-educated on pressure injury and non-pressure injury, need to review new or worsening skin impairments to ensure interventions are reviewed and care plan updated. 3. Re-education to nursing staff on 08/21/24 to monitor skin for injuries or changes with cares to ensure current he nurse if noted. 4. DON or designee to review facility charting for 2 weeks to ensure new admissions, readmissions, and current residents have skin impairments properly documented, orders implemented, and notifications completed and documented. This review will then be completed 5 days per week for 6 weeks or until substantial compliance maintained. 5. Audits will be completed for 8 weeks by DON or IDT to ensure in house residents with pressure injuries have established wound process in place including care plan review and evaluation. 6. Quality Assurance Performance Improvement (QAPI) meeting held on 08/21/24 to review pressure injury incident, discuss implementation of actions items as stated above. 40181 Example 2: R3 was admitted to the facility on [DATE] after an acute care hospital stay with the following diagnoses, in part, Parkinson's disease, polyosteoarthritis, and long term use of antibiotics. R3's admission assessment, dated 08/09/24, identified R3 had a Braden risk assessment score of 18, which indicated R3 was at risk for the development of a pressure injury. The admission assessment also identified R3 had a pressure injury on the left heel. The assessment did not identify the stage of the pressure injury or any measurements or description of the wound condition. R3's Minimum Data Set (MDS) assessment, dated 08/16/24, identified R3 was at risk for development of a pressure injury and had one unhealed stage 1 pressure injury. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All of the subsequent Weekly Skin Review documents identified R3 had no skin impairments. Surveyor was unable to identify any other documentation of assessment of the left heel pressure injury, or documentation stating the left heel pressure injury was resolved. R3's care plan included the following focus areas, in part: The resident has a pressure ulcer (left heel) r/t [related to] recent hospitalization . Date initiated: 08/09/2024. Goal: The resident's Pressure ulcer will show signs of healing and remain free from infection by/through review date. Date initiated: 08/09/2024. Interventions/Tasks: Administer treatments as ordered and monitor for effectiveness. Date initiated: 08/09/2024. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Date initiated: 08/09/2024 .Actual pressure wound at left heel r/t recent hospitalization /immobility. Date initiated: 08/09/2024. Goal: Show no signs of infection. Interventions/Tasks: Encourage and assist as needed to turn and reposition; use assistive devices as needed. Float heels as able. Follow up care with MD as ordered. Use pillows and/or positioning devices as needed. R3's order summary did not contain any treatment orders for care or treatment of the left heel pressure injury. On 08/20/24 at 11:40 AM, Surveyor observed R3 seated in a wheelchair in R3's room. R3 was dressed and had gripper socks on both feet. R3's heels were resting directly on the floor. R3 stated they thought they had a sore on their heel. On 08/20/24 at 12:38 PM, Surveyor observed R3 seated in a recliner in R3's room. The footrest on the recliner was elevated and R3's heels were resting directly on the foot rest. R3 had gripper socks on both feet and her heels were not floated. On 08/20/24 at 12:45 PM, Surveyor interviewed Certified Nursing Assistant (CNA) D and asked if R3 had any wounds or skin issues. CNA D was not aware of any wounds or skin issues for R3. Surveyor asked CNA D if they had any interventions for positioning or pressure relief for R3. CNA D stated they tried to encourage R3 to reposition every 2 hours. Surveyor asked if they were supposed to float R3's heels. CNA D was not aware of any interventions to float R3's heels. On 08/20/24 at 12:56 PM, Surveyor interviewed Registered Nurse (RN) H, who was caring for the residents on R3's hall, and asked if R3 had any wounds or pressure injuries. RN H stated they were not aware of any skin issues for R3. On 08/20/24 at 2:30 PM, Surveyor interviewed Assistant Director of Nursing (ADON) C, who stated they were the facility's wound nurse. Surveyor asked if there was additional documentation of assessments of R3's left heel pressure injury that was identified on admission to the facility. ADON C stated they were not aware of R3's pressure injury. ADON C stated when a staff member identifies a new wound on a resident, they are supposed to inform ADON C. ADON C will then assess the wound and open a weekly wound tracker and do weekly wound assessments and documentation until the wound is healed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/20/24 at 2:40 PM, Surveyor interviewed RN I, who stated R3 did have a previous pressure injury to the left heel when admitted from the hospital, but it had subsequently healed. RN I stated R3 did not have a current pressure injury to the left heel, but they neglected to update the care plan to reflect this. Surveyor asked RN I if there was documentation of an assessment of the left heel that showed the pressure injury had resolved. RN I stated they did not document an assessment of R3's heel showing the pressure injury had resolved. Surveyor asked if R3 was still at risk for development of pressure injuries. RN I stated R3 was still at risk for pressure injuries and staff should still follow the care plan and float R3's heels to prevent the recurrence of pressure injuries to R3's heels. Surveyor informed RN I of two observations of R3 seated without heels floated. RN I stated staff would be reeducated.