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F 000	INITIAL COMMENTS	F 000		

✓ Correction date 11/29/19

QM Complaints # 84113-C, # 86223-C and # 86250-C were investigated and substantiated.

See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C,

F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584	

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deedee MS, LMHP/LMHC	Provisional Admin	11/29/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation

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resident room, as specified in §483.90 (e)(2)(iv).

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, observation, family member and staff interviews and facility housekeeping direction and documentation, the facility failed to maintain an environment free of urine odors. The facility identified a census of 41 current residents.

Findings include:

1. Observation on the following dates and times revealed urine odors in the facility;
a. 9/30/19 at 11:15 a.m., with the odor stronger on the 200 and 300 resident halls.
b. 10/1/19 at 9 a.m., a strong urine odor in room 308.
c. 10/14/19 at 2:15 p.m. room 308.
d. 10/15/19 at 8 a.m., a mild urine odor on the 200 and 300 halls with the soiled linen barrel on the 300 hall smelling strongly of urine.
d. 10/16/19 at 9:20 a.m. room 308.

2. Review of the facility's census list revealed Resident #1 resides in room 308. The resident's MDS (Minimum Data Set) assessment dated 7/10/19 documented he required an indwelling

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urinary catheter and the assistance of one staff with hygiene activities.

On 10/14/19 at 2:57 p.m., Resident #1's family member stated she visited recently in the evening. Resident #1's room smelled badly like urine and everything smelled extremely bad.

3. Review of the facility's consus list revealed Resident #6 resides in room 308. The resident's MDS assessment dated 9/18/19 documented he required an indwelling urinary catheter and the assistance of one staff with hygiene activities.

During interview on 10/15/19 at 4:15 p.m., Resident #6's wife stated that her husband's room sometimes smells of urine. She has talked to staff about the concern, but the room still smells.

4. During interview on 10/16/19 at 11:03 a.m., the Maintenance Director stated he is also in charge of housekeeping, laundry and transportation. The facility does deep-cleaning of resident rooms every other day. Deep cleaning consists of dusting blinds, cleaning behind the TV, window screens, under heat registers and the tops of doors, closets and picture frames. Light cleaning is done daily which consists of sweeping and mopping floors, changing the bed and cleaning the mattress if the resident is out of the room. When asked if efforts were made towards controlling urine odors, the Maintenance Director stated staff mops the floors with disinfectant and stripped and cleaned resident beds. For soiled linen storage barrels, either housekeeping or nursing staff should disinfect them once a week, but the task had not been assigned to specific staff. During the interview, the surveyor and

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F 584	Continued From page 3 Maintenance Director walked to room 308 and when asked to take a deep breath in room 308, the Maintenance Director stated he could smell a urine odor. He stated the facility had no policy and procedure guidance for housekeeping duties but he could provide a list of resident rooms that had been deep cleaned recently. Review of the deep-cleaning list of resident rooms showed that room 308 had been deep-cleaned last on 9/13/19 and prior to that, on 8/15/19. During interview on 10/16/19 at 11:40 a.m., the Director of Nursing stated on 10/5/19, Resident #1's family members were upset about the urine odor in his room when they visited.	F 584		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes	F 660		

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(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that

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the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, resident and staff interviews and facility policy review, the facility failed to ensure a resident had discharge instructions and home health referrals for one of two discharged residents reviewed (#7). The facility identified a census of 41 current residents.

Findings include:

According to the Minimum Data Set (MDS) assessment dated 7/30/19, Resident #7 had intact memory and cognitive abilities, as evidenced by a brief interview for mental status score of 15. The resident's diagnoses included chronic lung diseases, muscle wasting and atrophy and lower back injuries. The assessment documented he required setup help with walking, dressing and personal hygiene and assistance to transfer with bathing. The resident had active discharge planning in place at the time of the assessment.

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The resident's care plan, with the targeted goal date of 4/25/19, identified he required discharge planning related to his desire to return to home. The care plan instructed, in part, to review community resources as indicated/needed prior to discharge, to identify any community supports that may benefit him and assist the resident in implementing their involvement and to assure that continuity of care is being maintained by completing and providing a detailed discharge summary of the plan of care.

The facsimile (fax) to Resident #7's physician dated 10/14/19 documented the resident would like to discharge to home and his apartment was ready. Staff requested orders to have home health evaluate and continue to treat him at home with his activities of daily living. The physician approved the resident's discharge and referrals. The facility received the faxed order on 10/4/19 (Friday) at 6:15 a.m., but it contained no nursing notation of receipt and implementation.

The Discharge Summary dated 10/8/19 at 2:30 p.m. documented that due to miscommunication, Resident #7 left the facility with family to discharge home without medication and discharge instructions. The Director of Nursing (DON) called the resident and explained he was not aware he needed any and his ride was there so he left. The DON went over discharge information over the phone and gathered his medications. The facility's Respiratory Therapist (RT) would deliver the instructions and medication to his home and have him sign discharge paperwork to return to the facility. The resident stated he had no concerns regarding medications or discharge at the time. The entry of 10/9/19 at 7:39 a.m. documented the RT took

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the resident's medications, discharge summary and discharge medication list to his home on 10/8/19 at 3:30 p.m. The resident had no questions at the time and the RT asked that he call her number (provided) with any questions.

On 10/14/19 at 2:45 p.m., the Business Office Manager (BOM) stated she informed Resident #7 he had no home health services yet, but he wanted to go. The BOM did not document that conversation. The BOM stated she had not called yet to follow up with Resident #7. The SW, who shared an office with the BOM, stated she heard the conversation and that she also had not called Resident #7 to follow up after discharge.

On 10/14/19 at 3 p.m. Resident #7 stated he got his apartment on 10/2 or 10/3/19. The facility got the discharge order from his physician on 10/4/19 with plans for his family members to come and get him on 10/8/19. The BOM told him that home health would be at his apartment on 10/9/19. Resident #7 recalled he told everyone in the facility about his pending discharge, everyone he saw, that he would be leaving on 10/8/19, so the facility had all of 10/4, all of 10/7 and half of 10/8/19 to get everything ready for discharge. He reported his ride was there and they didn't even have medications ready. The facility had the RT drop them by later. Resident #7 stated there are things he needed help with, as he no longer had a wheelchair and needed a different walker. He stated he took care of himself the first day or two but it's been rough getting around. The resident had not received home health services yet, but they planned to come on 10/15/19. He also reported nobody from the facility had followed up with him yet.

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On 10/14/19 at 3:30 p.m., the DON stated she did not work on 10/4/19. She has a designee to answer questions, but not for home health referral and usually the nurse on duty starts the work toward a resident discharge. At 3:35 p.m., the BOM stated she received notice of Resident #7's discharge on 10/7/19 and faxed the information to home health, but she could not provide a copy of the fax. She then had to re-fax the information at the request of home health staff.

During a phone interview on 10/14/19 at 3:50 p.m., the home health staff member stated she received first contact from the BOM on 10/8/19 regarding referral for Resident #7. The home health agency decided not take the resident on as they had a current lack of staff.

On 10/14/19 at 4:15 p.m., Staff A RN (Registered Nurse) stated if she received a faxed home discharge order, she would go right to the DON and if unavailable, the MDS Coordinator. She reported she had completed 2 resident home discharges and she got help with both.

On 10/15/19 at 10:43 a.m., the RT stated she saw the resident's discharge orders on 10/4/19 and put them on the nurse's computer; she later saw them moved to the nursing basket on 10/4/19 and then saw they were still there on 10/7/19.

The facility's Discharge Plan/Summary Voluntary procedure dated 11/1/18 instructed a summary is completed upon resident discharge to assure continuum care needs for the resident. Guidelines included:

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F 660	Continued From page 9 Point #2 - Upon notification of impending discharge, the interdisciplinary team should be notified to allow staff the opportunity to educate and implement a safe discharge. Social work should coordinate the discharge planning process (documentation in the clinical record identified no SW involvement with this discharge) Point #6 - When the resident is discharged home, referrals needed should be made to home health or others based upon the needs of the resident. Point #8 - Any needed assistive devices should also be arranged and referrals for home care should be made and coordinated with Social Services. Point #11 - Nursing should meet with the person responsible for the resident at home and provide instruction to that person(s) as appropriate in regard to medications and treatments to be continued at home. Referral should be ensured for home care as needed and coordinate same with Social Services. Any unused medications that are currently ordered after discharge may be sent with the resident prior to discharge according to state regulations.	F 660		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices This REQUIREMENT is not met as evidenced by:	F 684		

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Based on clinical record review, staff and physician interviews, and facility policy review, the facility failed to provide needed referrals, treatments and staff communication of status changes regarding a skin abrasion that worsened to the point the Achilles tendon, fat, and connective tissue were visible. The area became infected, sepsis developed, and the resident required hospitalization, surgery, and a right leg (below the knee) amputation for one of two discharged residents reviewed (Resident #3). The facility identified a census of 41 current residents.

Findings include:

According to the Minimum Data Set (MDS) assessment tool dated 3/13/19, Resident #3 had diagnoses that included heart failure, high blood pressure, diabetes mellitus, anxiety, depression, atrial fibrillation and weakness. The assessment documented the resident had an intact memory and cognition as evidenced by a brief interview for mental status score of 15. The assessment recorded Resident #3 did not walk, required the assistance of two staff with transfers and dressing and the assistance of one staff with bed mobility, eating, toilet use and personal hygiene. Resident #3 had the risk of developing pressure ulcers and had one Stage 3 ulcer at the time of the assessment. The MDS documented treatments that included pressure reducing devices for her chair and bed.

The resident's Care Plan, revised on 1/14/19, documented Resident #3 had the potential for skin breakdown related to obesity, diabetes, peripheral neuropathy, peripheral vascular disease and previous wounds. Interventions included to consult with the wound clinic per

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orders and to consult with a would nurse specialist as needed. The Care Plan also directed staff to provide wound treatments as ordered.

During an interview on 9/30/19 at 3:15 p.m. the DON (Director of Nursing) stated she is the facility's primary wound nurse. When asked, she reported she documented assessments in the Skin QI logs but had not transferred them to the facility's electronic health record yet.

A Nurses note dated 4/17/19 at 11:49 p.m. documented a dressing to the resident's right Achilles as clean, dry, and intact. The progress notes did not identify a source of the right Achilles wound.

During interview on 10/2/19 at 9:35 a.m., the DON stated the facility had no incident report, no progress note entries, and no investigation as to the injury to the resident's right Achilles. She thought the injury may have occurred during a surface to surface transfer or a bath.

The Skin Quality Improvement (QI) Log for Non-Pressure skin conditions (used by the facility to document wound assessments and treatments) recorded the following information:
a. 4/16/19 - Resident #3 had an abrasion to her right Achilles which measured 2 by 2 cm (centimeters) and had no depth. The treatment included a collagen matrix covered with a bordered foam dressing to be changed daily (the resident's clinical record did not contain an order for this treatment).
b. 4/23/19 - The right Achilles abrasion measured 2 by 2 cm and treatment continued with collagen matrix covered with a bordered foam dressing to be changed daily.

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c. 4/30/19 - The right Achilles abrasion now measured 3 by 1 cm with a depth of 0.1 cm, worsening, with a treatment documented as moistened Aquacell covered with a foam dressing and Kerlix (the resident's clinical record did not contain an order for this treatment).
d. 5/7/19 - Measurements and treatment remained unchanged from 4/30/19.
e. 5/14/19 - The right Achilles abrasion measured 2.5 by 2 cm with a depth of 0.1 cm with continued treatment of moistened Aquacell covered with a foam dressing and Kerlix.
f. 5/21/19 - Measurements and treatment remained unchanged from 5/14/19.
g. 5/28/19 - The right Achilles abrasion measured 2.5 by 2.5 cm with depth of 0.3 cm. The log documented treatment of collagen sprinkles and bordered foam dressing. Staff documented the wound had worsened.
h. 6/4/19 - The abrasion measured 2.8 by 2.0 cm with a depth of 0.2 cm., improving, with treatment of hydrogel/collagen matrix AG covered with a foam dressing.
i. 6/11/19 - The resident's right Achilles abrasion measured 4 by 3 cm with a depth of 0.2 cm, improving, with treatment of hydrogel/collagen matrix AG covered with a foam dressing changed twice a day.
j. 6/18/19 - The right Achilles abrasion now measured 6.5 cm by 3.9 cm with a depth of 1 cm. Treatment included Betadine with a foam dressing and Kerlix wrap.
k. 6/25/19 - The wound measurements and treatment were unchanged from 6/18/19.

During interview on 10/2/19 at 10:10 a.m., the DON stated she would call the physician's office to find the orders for Resident #3's wound care as documented on the 4/16 and 4/30/19

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	166230	A. BUILDING _____ B. WING _____	C 11/05/2019

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OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

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documented in the Skin QI Log for Non-Pressure skin conditions. On 10/14/19 at noon, the DON stated she looked through all of Resident #3's records and could not find the wound treatment orders of 4/16 and 4/30/19.

The resident's Progress Notes documented the following:
a. 5/27/19 at 7:51 p.m. - A Nurses note documented the open area of the resident's Achilles wound as slightly reddened around the edges with an open area of connective tissue and a faint, foul odor.
b. 5/31/19 at 2:58 p.m. - A Skin/Wound Note documented an odor and some drainage present to the right Achilles wound.
c. 6/1/19 at 4:35 a.m. - A Skin/Wound Note documented a minimal amount of drainage present to the wound with an odor noted and appearance of different stages of healing.
d. 6/8/19 at 2:22 p.m. - A Skin/Wound Note documented the wound continued to have an odor and had a small amount of drainage at that time.
e. 6/12/19 at 1:52 p.m. - A Skin/Wound Note documented staff changed the right Achilles dressing, noting scant drainage and continued odor.
f. 6/13/19 at 10:14 a.m. and 6/14/10 at 10:37 am - Both documented moderate drainage and odor from the right Achilles wound.
g. 6/19/19 at 2:08 p.m. - Treatment to the right Achilles recorded and the wound had no odor. The note documented the resident currently received an antibiotic.
h. 6/20/19 at 1:38 p.m. - During a dressing change, staff noted a foul odor to the wound with scant drainage and redness and warmth to her right leg.

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i. 6/24/19 at 8:05 p.m. - Staff cleansed the resident's right Achilles wound and noted a foul odor present in the room without dressing removal.
j. 6/26/19 at 2:49 p.m - The resident complained of right leg pain at a 10 on a 0-10 scale, with 10 being the worst imaginable pain. Staff gave the resident two Tylenol per orders.
k. 6/27/19 at 9:58 a.m. - The resident admitted to the hospital with sepsis (blood infection).

On 10/14/19 at 10:20 a.m. the DON stated nurses would not document the appearance of a resident's wound when providing treatments, but would document the appearance of a dressing (despite the presence of odor with dressing changes).

Review of the resident's clinical record revealed no physician orders for the treatments documented in the Skin QI - Non Pressure Log on 4/16 and 4/30/19. On 10/14/19 at noon, the DON stated the 4/16/19 and 4/30/19 wound treatment orders could not be found.

The Physician's Order and Progress Notes dated 6/14/19 revealed Resident #3 transferred care from her previous physician because she did not wish to travel for visits to her prior physician's office. The resident's new care provider documented the resident had a post calf wound being addressed by (the) wound care (clinic) and ordered a wound care consult, Doxycycline (an antibiotic) 100 mg twice daily for 14 days, and blood tests.

The Wound clinic progress note dated 6/18/19 documented Resident #3 had a new ulcer on the back of her right ankle with an exposed tendon

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and a foul odor. The note revealed the resident had no cellulitis or redness of the foot or ankle and did not complain of pain during the visit. The Wound clinic staff identified the wound as a Stage 4 wound with etiologies (the cause(s) or manner of causation of a disease or condition) of pressure and diabetic wound ulcers of the lower extremities. The right ankle wound measured 16.4 by 4 cm with a 1 cm depth with visible tendon, fat layer and fascia (a band or sheet of connective tissue beneath the skin that attaches, stabilizes, encloses, and separates muscles and other internal organs). The wound showed a large amount of drainage and a foul odor after cleansing. Wound clinic staff identified a small area of granulation (healing) tissue in the wound bed and large amount of necrotic (dead) tissue in the wound bed.

The facility's Discharge list documented Resident #3 discharged from the facility on 6/27/19.

Resident #3's Hospital Discharge Document dated 7/8/19 documented she admitted directly to the hospital on 6/27/19 for septic shock from right acute on chronic wound infection. The resident was found to have sepsis (blood infection) due to a right foot infection. She immediately started on intravenous fluids and broad spectrum antibiotics. The resident underwent a right leg (below the knee) amputation and discharged from the hospital to another nursing facility on 7/9/19.

On 10/7/19 at 9:22 a.m. the resident's former physician stated she last saw Resident # 3 in December of 2018. The resident should have had a follow up appointment in February of 2019, but did not come or was not scheduled. The physician's records showed little information

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regarding the right Achilles tendon tear and she had no records of facility staff requesting treatment changes on 4/16 or 4/30/19. The physician stated if facility staff contacted them after hours, clinic staff would phone or fax orders. The facility then sent the orders back for signature and they scan them into the clinic EMR (electronic medical record). The physician stated they had no records for any wound orders for 4/16 or 4/30/19. The facility sent the physician faxes on 5/16/19 and on 6/5/19 stating the right Achilles tendon wound was healing well. In June 2019, she received a call from the wound care physician. He informed her the resident's Achilles wound was infected and he could see her tendon; he asked what they should do and she recommended the resident be seen in the hospital. Following review of the facility's documented assessments, the physician wondered how the wound have changed so much in that short period of time. However, if the wound was worsening, they should have contacted the physician or the Wound clinic immediately. Resident #3 had been seen for a long time by the Wound clinic, so they were familiar with her care. The resident also stayed in close communication; she cared about her own health. They really should have been looking at her wounds every day, weekly would not have been sufficient for her.

On 10/15/19 at 10:50 am, when asked why Resident #3 had no referral to the Wound clinic until 6/19/19, the DON stated they made the referral in June when the resident started seeing a new physician. The DON stated the wound appeared to be healing and she is usually pretty good at healing resident wounds. When the wound worsened, she requested a Wound clinic

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referral.

On 10/29/19 at 1:48 p.m., Staff A, RN (Registered Nurse) stated that if she assessed changes in a resident's wound she would communicate the changes to the DON via a phone call or text and tell the oncoming shift. Staff A stated she has called the DON if she was really concerned

On 10/29/19 at 1:50 p.m., Staff B, RN stated put any changes in a resident's wound status on the facility's 24 hour report and in the resident's clinical record. She would also tell the oncoming shift.

On 10/29/19 at 1:54 p.m., the DON stated nurses usually tell her of any changes to a resident's wound. She did not recall anyone telling her the resident's right Achilles wound had an odor, but sometimes wounds have odors. She did not recall any odors when assessed Resident #3's wound.

The facility's Skin Management Guidelines, revised 7/17, primarily offered information about treatment of pressure injuries. The facility submitted the guidelines when requested to provide direction regarding wound prevention, assessment and treatment. The guidelines instructed that At-Risk review meetings would be conducted to review/discuss residents identified at risk or with compromise, treatment modalities and interventions and recommendations based on interdisciplinary evaluation. Under the section titled Lower Extremity Ulcers, the guidelines instructed staff to monitor the area closely during treatment to evaluate the appropriateness of the treatment regimen and that consultation with a Certified Wound Care Nurse or surgeon may be

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appropriate

F 686 SS=D — Treatment/Svcs to Prevent/Heal Pressure Ulcer
CFR(s): 483.25(b)(1)(i)(ii)

§483.25(b) Skin Integrity
§483.25(b)(1) Pressure ulcers.
Based on the comprehensive assessment of a resident, the facility must ensure that-
(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, and facility policy review, the facility failed to ensure staff implemented planned interventions in order to prevent development of a facility acquired pressure ulcer for one of two discharged residents reviewed (Resident #3). The facility identified a census of 41 current residents.

Findings include:

According to the Minimum Data Set (MDS) assessment dated 3/13/19, Resident #3 had diagnoses that included heart failure, high blood pressure, diabetes mellitus, anxiety, depression, atrial fibrillation, and weakness. The assessment documented the resident had intact memory and cognition as evidenced by a brief interview for mental status score of 15. The assessment

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recorded Resident #3 did not walk, required the assistance of two staff with transfers and dressing and the assistance of one staff with bed mobility, eating, toilet use, and personal hygiene. Resident #3 had the risk of developing pressure ulcers and had one Stage 3 ulcer at the time of the assessment. The MDS documented treatments that included pressure reducing devices for her chair and bed.

The resident's Care Plan, revised on 1/14/19, documented she had the potential for skin breakdown related to obesity, diabetes, peripheral neuropathy, peripheral vascular disease and previous wounds. An intervention dated 12/21/18 directed staff to place a Prafo boot (to create an air space around the back of the heel, alleviating pressure and preventing heel ulcers) on the resident's right foot at all times as directed by the wound clinic. An additional intervention dated 4/8/14 instructed staff to float the resident's heels when in bed per resident request

The Skin/Wound Note dated 4/29/19 at 8 a.m. documented the DON (Director of Nursing) noted a fluid filled blister to the resident's right heel which measured 4.5 by 3.5 cm (centimeters) and without depth. The DON noted the resident did not wear her pressure relieving boot on the right foot and no heel lift cushion to the bed. The DON educated staff regarding the use of pressure relieving devices as directed by the care plan.

The Pressure Wound QI (Quality Improvement) Log (used by the facility to track wound assessments) documented on 4/29/19, staff first saw a pressure ulcer on the resident's right heel. The log documented the ulcer measured 3.5 cm by 3.0 cm on that date. Continued review of the

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log showed the pressure ulcer healed on 5/21/19.

During an interview on 10/15/19 at 10:20 a.m., the DON stated the resident's right heel blister occurred due to pressure and healed quickly. Staff received education to use the resident's Prafo boot.

The facility's Skin Management Guidelines, dated 7/17, documented that residents who are at risk or with wounds and/or pressure injury are provided appropriate treatment to encourage healing and/or integrity.

Oakland Manor
by MGM Healthcare

NOVEMBER 2019 DIA INVESTIGATION – PLAN OF CORRECTION

Submission of the response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interested against the facility, the Executive Director, or other associates, agents, or other individuals who draft or may be discussed in this response and plan of correction. Preparation and submission of this plan of correction does not constitute an admission of agreement of any kind by the facility of the truth of any fact alleged or the correctness of any conclusion set forth in these allegations by the survey agency.

F 584 SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

1. **Elements detailing how you will correct the deficiency as it relates to the individual.**
   Housekeeping staff immediately deep cleaned room 308, 200 and 300 hallways and the facility was free of odors on 10/17/19.

2. **Who has the potential to be affected?**
   All residents have the potential to be affected.

3. **Include measures you will take or systems you will alter to ensure that the problem does not recur.**
   Maintenance Director in-serviced housekeepers on facility cleaning schedule on 11/22/19.

4. **How you plan to monitor performance to make sure that solutions are permanent.**
   Maintenance Director will monitor through facility audit tool 5x/week for 4 weeks and then monthly to ensure ongoing compliance. Monitored findings will be reviewed during monthly QAPI meetings.

5. **Date of Compliance:** 11/29/19

F 660 DISCHARGE PLANNING PROCESS

1. **Elements detailing how you will correct the deficiency as it relates to the individual.**
   A. Social Services contacted resident #7 to set up home health on 10/21/19.
   B. Administrator in-serviced social services director and business office on discharge policy and procedures on 11/21/19.

2. **Who has the potential to be affected?**
   Any resident discharging home has the potential to be affected.

3. **Include measures you will take or systems you will alter to ensure that the problem does not recur.**
   Discuss discharge policy and procedure with all staff on 11/26/19.

4. **How you plan to monitor performance to make sure that solutions are permanent.**
   Administrator will monitor through facility audit tool 2x/week for 4 weeks and then monthly to ensure ongoing compliance. Monitored findings will be reviewed during monthly QAPI meeting.

5. **Date of Compliance:** 11/29/19

F684 QUALITY OF CARE

1. **Elements detailing how you will correct the deficiency as it relates to the individual.**
   A. DON completed 100% audit on all wounds to determine no decline on 11/12/19.
   B. Administrator in-serviced DON on obtaining referrals for specialists on all declining wounds in a timely manner on 11/25/19.

2. **Who has the potential to be affected?**
   Any resident potential to be affected.

3. **Include measures you will take or systems you will alter to ensure that the problem does not recur.**
   DON in-serviced all staff on recognizing changes in conditions and identifying changes in wounds on 11/26/19.

4. **How you plan to monitor performance to make sure that solutions are permanent.**
   DON will monitor through facility audit tool 5x/week for 4 weeks and then monthly to ensure ongoing compliance. Monitored findings will be reviewed during monthly QAPI meeting.

5. **Date of Compliance: 11/29/19**

F 686 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE ULCER

1. **Elements detailing how you will correct the deficiency as it relates to the individual.**
   DON completed 100% audit on all residents with pressure ulcers to ensure interventions are in place on 11/14/19.

2. **Who has the potential to be affected?**
   Any resident with pressure ulcers potential to be affected.

3. **Include measures you will take or systems you will alter to ensure that the problem does not recur.**
   DON in-serviced all staff on utilizing pressure relieving devices on 11/26/19.

4. **How you plan to monitor performance to make sure that solutions are permanent.**
   DON will monitor through facility audit tool 5x/week for 4 weeks and then monthly to ensure ongoing compliance. Monitored findings will be reviewed during monthly QAPI meeting.

5. **Date of Compliance: 11/29/19**