

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2021
NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1212 INDIAN HILLS DRIVE BURLINGTON, IA 52601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS Correction date: _____ The following deficiency relates to the investigation of Facility Reported Incidents #96809, #96810, and #96811 and Complaints #96222, #97254, and #98877 conducted August 3 - 12, 2021. Complaints #96222, #97254, and #98877 were substantiated. Facility Reported Incidents #96809, #96810, and #96811 were not substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000			
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: Based on clinical record review, policy review, hospital record review, and staff interview, the facility failed to document wound care treatment, assess wounds, and report signs of infection timely for a surgical wound in 1 of 5 sampled (Resident #5) with wounds. This resulted in Resident #5 being hospitalized for surgical	F 684	Past noncompliance: no plan of correction required.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

08/26/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2021
NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1212 INDIAN HILLS DRIVE BURLINGTON, IA 52601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 1</p> <p>debridement of the wound. The facility reported a census of 48 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) dated 7/15/20 documented Resident #5 admitted to the facility on 7/8/20 and had a Brief Interview for Mental Status (BIMS) score of "11" indicating moderately impaired cognition. The MDS documented diagnoses of diabetes, morbid obesity, and encounter for surgical aftercare following surgery on the skin and subcutaneous tissue. The resident had surgical wounds receiving surgical wound care by the facility.</p> <p>The Care Plan documented Resident #5 had surgical incisions/wounds to the abdomen, right thigh, and left foot. The Care Plan dated 7/17/20 directed the staff to:</p> <p>a. Administer antibiotic as ordered.</p> <p>b. Assess the surgical wounds weekly for progress with healing.</p> <p>c. Monitor and drain Jackson Pratt (JP) drain as ordered.</p> <p>d. Monitor for signs and symptoms of infection: pain, redness, swelling, warmth, loss of function. Notify provider if present.</p> <p>e. Treatment as ordered.</p> <p>Hospital Discharge Summary Notes dated 7/8/20 directed wound care:</p>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2021
NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1212 INDIAN HILLS DRIVE BURLINGTON, IA 52601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 2</p> <p>a. Abdominal incision: keep incision clean, dry and intact</p> <p>b. Right abdominal JP drain: keep in place until follow-up</p> <p>c. Left ankle: to remain covered in xeroform gauze In addition, it directed Resident #5 to take Keflex (an oral antibiotic) for 7 days. It did not address treatment for the right thigh skin graft.</p> <p>A Progress Note dated 7/8/20 documented Resident #5 had the following surgical incisions/wounds:</p> <p>a. Midline surgical incision measured 31centimeters (cm) by 0.3 cm.</p> <p>b. Hardened area right of midline incision measured 10 cm in diameter.</p> <p>c. Unable to assess the top left foot.</p> <p>d. Skin graft to right thigh measured 15 cm by 9 cm.</p> <p>e. Hardened area around Jackson Pratt drain measured 5 cm by 7 cm.</p> <p>Review of the Skin Condition Record sheets revealed the facility failed to measure the surgical sites/wounds from July 8, 2020 to July 20, 2020. The sheets revealed the following measurements:</p>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2021
NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1212 INDIAN HILLS DRIVE BURLINGTON, IA 52601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 3</p> <p>a. The midline abdomen on 7/20/20 measured 27 cm by 5 cm (increased in width since admit).</p> <p>b. The hardened right midline abdomen surgical incision on 7/8/20 measured 10 cm in diameter. On 7/20/20 measured 17 cm by 12 cm (increased in size since admit).</p> <p>c. The top left foot surgical site on 7/8/20 unable to assess.</p> <p>d. The right thigh skin graft on 7/8/20 measured 15 cm by 9 cm.</p> <p>e. The hardened area around the Jackson Pratt drain site measured 5 cm by 7 cm on 7/8/20. On 7/20/20 the area measured 5 cm by x 3 cm with epithelial tissue and serosanguineous drainage</p> <p>The facility's Order Summary Report indicated orders dated: On 7/8/20 for cephalexin (generic Keflex) until 7/15/20.</p> <p>a. On 7/8/20, Cephalexin (generic Keflex) until 7/15/20.</p> <p>b. On 7/15/20, Complete Blood Count (CBC) and Basic Metabolic Panel (BMP) on 7/20/20.</p> <p>c. On 7/17/20, remove the JP drain on 7/20/20 if drainage remained less than 25 milliliters (mL) per day.</p> <p>A Nursing Home Documentation Sheet revealed Resident #5's Primary Care Provider saw her for a routine visit on 7/15/20. The provider noted a midline (abdominal) dressing with a drain, a</p>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2021
NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1212 INDIAN HILLS DRIVE BURLINGTON, IA 52601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 4</p> <p>compression dressing on the left ankle, and healing graft. The provider ordered a CBC and BMP for the following week and did not note any reports of, or concerns for, infection.</p> <p>The facility's Order Summary Report failed to document any treatment orders for the right thigh skin graft. It also failed to address the abdominal incision treatment until 7/20/20 when orders were added:</p> <p>a. Gauze pad over JP removal site twice daily</p> <p>b. Abdominal (gauze) pad twice daily to midline abdominal incision</p> <p>c. Silvadene cream (topical antibiotic) to abdominal incision twice daily</p> <p>The Treatment Administration Record (TAR) showed no treatment orders for the right thigh skin graft site and no treatment orders for the abdominal incision until 7/20/20.</p> <p>The Medication Administration Record (MAR) showed no treatment orders for the right thigh skin graft site and no treatment orders for the abdominal incision.</p> <p>Progress Note entries revealed nurse documentation:</p> <p>a. On 7/15/20 at 9:57 PM: Firm red, non-warm area mid right side of abdominal dressing. Distal end of dressing loose with foul smell. Reinforced with opsite (adhesive) dressing. Resident complaining of intermittent right lower abdominal</p>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2021
NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1212 INDIAN HILLS DRIVE BURLINGTON, IA 52601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 5 discomfort</p> <p>b. On 7/16/20 at 5:15 AM: Resident complained of intermittent right lower abdominal discomfort. Pain medication given with good results</p> <p>c. On 7/17/20 at 5:42 AM: Resident complained of intermittent right lower abdominal discomfort. Pain medication given with good results</p> <p>d. On 7/17/20 at 10:32 PM: Has abdominal incision that is covered, a skin graft site- changed dressing on it, and changed dressing to left foot. Emptied 5 mL of putrid smelling brown liquid drainage from JP drain in abdomen.</p> <p>e. On 7/18/20 at 9:30 PM: Abdominal dressing changed. Had foul smelling drainage. Area cleansed with sterile water, telfa (not adherent) and abdominal (absorbent) dressings applied.</p> <p>f. On 7/19/20 at 9:28 PM: Abdominal dressing changed using telfa and abdominal dressings. Slightly foul odor. Scant amount of brownish yellow drainage.</p> <p>g. On 7/20/20 at 2:37 PM: JP drain removed with a 5 x 3 cm incision underneath and mucous-like drainage. Midline abdominal incision measuring 27 x 5 cm with surrounding skin a deep red color. Area oozing with a very foul odor. The bottom of the incision looks at if dehiscing and becoming necrotic (tissue death). The hardened area seems to be spreading, measuring 17 x 12 cm. Specialty physician and local nurse practitioner updated.</p> <p>h. On 7/20/20 at 3:14 PM: New orders received for abdominal pads over the abdominal incision.</p>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2021
NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1212 INDIAN HILLS DRIVE BURLINGTON, IA 52601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 6</p> <p>i. On 7/20/20 at 3:51 PM: New orders received for silvadene cream to the abdominal incision and an appointment on 7/21/20 at the clinic.</p> <p>j. On 7/20/20 at 5:33 PM: Facility set up ambulance transfer as ordered by Advanced Registered Nurse Practitioner (ARNP) as medically necessary for transport to 7/21/20 appointment.</p> <p>The Clinical Record lacked documentation of the appearance of the abdominal incision from 7/8/20 until 7/20/20 and a lack of Physician notification of the odorous drainage from the abdominal incision from 7/15/20 until 7/20/20.</p> <p>A Phone Message/Call document dated 7/21/20 from Advanced Registered Nurse Practitioner (ARNP) to local Physician stated the facility called her (ARNP) on 7/20/20 about the resident's wound having a small open area with green, foul-smelling, mucus present when removing the JP drain. The resident's labs showed a white blood cell (WBC) of 14.9, likely from the wound infection.</p> <p>A Plastic Surgery Note dated 7/21/20 documented Resident #5 presented to the clinic for post-operative follow up. Resident #5 had a status of post left lower extremity reconstruction with free retus abdominis flap and split thickness skin graft on 6/2/9/20. Plastic Surgery Nurse spoke to facility on 7/17/20 to discuss Jackson Pratt drainage outputs. A follow up call placed to the facility on 7/20/20, at which time a Nurse reported areas of necrosis to Resident #5's midline abdominal incision. Resident #5 presented to clinic today with large area of tissue</p>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2021
NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1212 INDIAN HILLS DRIVE BURLINGTON, IA 52601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 7</p> <p>necrosis to the midline abdomen.</p> <p>A Discharge Summary from the hospital noted an admission date of 7/21 20 and a discharge date of 8/4/20. Resident #5 admitted from the clinic for abdominal wound dehiscence and infection. The resident underwent wound debridement in the operating room on 7/22/20 and 7/30/20 and at bedside on 8/3/20. Treatment included a wound vac (negative pressure wound treatment) and intravenous (IV) and oral antibiotics.</p> <p>The Protocol for Skin Care policy dated 9/05 directed the following:</p> <p>a. Visual assessment with every dressing change, documented assessment at least weekly.</p> <p>b. Documented assessment includes: size in centimeters, depth, condition of surrounding skin, presence of drainage, odor, amount, condition of wound bed, current treatment and response, watching for symptoms of wound infection (foul-smelling drainage, inflammation of tissue around wound, fever), and medical intervention if the wound is infected (notification of doctor, progress note by physician and treatment order from physician).</p> <p>On 8/9/21 at 1:55 p.m., Staff A (Registered Nurse) stated the nurses' measure and assess the wounds on Tuesdays or Wednesdays, half each day split up between the morning and evening shifts.</p> <p>On 8/10/21 at 11:05 a.m., the MDS Coordinator reported wound treatment orders are normally on</p>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2021
NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1212 INDIAN HILLS DRIVE BURLINGTON, IA 52601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 8</p> <p>the TAR, occasionally on the MAR. Signs of infection include redness, drainage, smell, and an increase in size of a wound. Staff should report any of these symptoms to the provider and follow-up within a day if no response.</p> <p>On 8/10/21 at 12:20 p.m., Staff B (Licensed Practical Nurse) reported wound treatment orders are in the electronic health record on the MAR or TAR. Signs of wound infection include swelling, redness, tenderness, area warm to the touch, or the presence of pus. Staff should report these symptoms to a provider right away so the wound does not get worse.</p> <p>On 8/11/21 at 4:30 p.m., The Director of Nursing (DON) stated nurses are expected to measure wounds and document the assessment every 7 days. If the wounds worsen, staff should notify the doctor and request new orders.</p> <p>Review of the In-Service Attendance Sheets dated 7/22/20 at 1:00 p.m., 2:00 p.m., and 3:00 p.m. revealed the Director of Nurses Provided staff education on the facility protocol for skin assessments which included continuous skin observations by direct care staff, reporting areas to the nurse, addressing skin areas with daily skilled charting, what to do if a new skin area develops, what to do if an area worsens, when to notify the Physician and Dietitian, what to do when an area heals, and not to apply a bandage without a Physician's order unless used to control bleeding or further injury until an order is received.</p> <p>This was considered past non-compliance as the facility took the above actions prior to the visit and no new concerns were identified.</p>	F 684			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2021
NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1212 INDIAN HILLS DRIVE BURLINGTON, IA 52601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	