STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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** Based on record review and staff interviews, the facility failed to notify the physician when residents underwent a significant change in status for 2 of 3 residents reviewed (Residents #2 and #9). The facility reported a census of 31 residents. Findings include: 1. The quarterly Minimum Data Set ((MDS) dated [DATE] for Resident #2 documented the resident demonstrated intact cogniton, remained totally dependent on 2 staff for surface to surface transfers, and on 1 staff for dressing and toilet use. The MDS also documented the resident had [DIAGNOSES REDACTED]. The Care Plan dated 3/16/20 revealed Resident #2 was at risk for contracting Covid-19 and having fatal complications. The Care Plan directed staff to follow CDC guidelines and recommendations for Covid-19 and to notify the physician for an elevated temperature and respiratory symptoms. Review of the Progress Notes for Resident #2 revealed the following: a. On 7/31/20: Resident and family informed he tested positive for Covid-19. b. On 8/2/20: Oxygen saturations 80 percent. Resident placed on oxygen. c. 8/3/20: Resident lethargic and refused to eat. Temperature 100.5 with family updated but the clinical record lacked documentation that showed staff updated the physician. d. On 8/4/20 Residents son called requesting to have the physician called. Staff faxed the physician and received order to send the resident to the emergency room . 2. According to the quarterly MDS dated [DATE], Resident #9 had [DIAGNOSES REDACTED]. The MDS revealed the resident scored 10/15 for the Brief Interview of Mental Status (BIMS), which meant the resident showed moderately impaired cognition. The MDS indicated she required extensive assist of 1 staff for transfers, dressing, toilet use and bathing. The Care Plan dated 6/22/20 revealed Resident #9 was at risk for contracting Covid-19 and having fatal complications. The Care Plan directed staff to follow CDC guidelines and recommendations for Covid-19, monitor vital signs every shift, and to report any status change to the physician. Review of the Progress Notes for Resident #9 revealed the following: a. On 7/25/20, Resident currently on isolation for positive Covid-19 with diminished lung sounds and labored respirations. b. On 7/26/20 Resident's respirations labored and lung sounds diminished. c. On 7/27/20 Resident short of breath with a dry cough, lungs diminished, oxygen saturation of 79 percent, and temperature of 99.5. d. On 7/28/20 Oxygen saturation 43 percent with shortness of breath and exertional dyspnea. e. On 7/29/20 Resident now having intermittent confusion with oxygen saturations 72-85% on 10 liters of oxygen, and skin was clammy and pale. Physician notified and resident sent to the emergency room per his orders. Resident was admitted to the hospital. During an interview on 8/13/20 at 11:00 AM with the Director of Nursing she stated she could not find physician notification for Resident #2 prior to 8/4/20 or for Resident #9 prior to 7/29/20. During an interview on 8/19/20 at 2:40 PM with the DON she provided the facility policy on Notification Of A Change In A Resident's Condition dated 11/1/18 and stated she expected the nurses to follow the policy. The policy directed staff to notify the physician immediately if the assessment was not a normal characteristic for the resident.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the right to confidentiality and privacy for 1 of 19 residents reviewed (Resident #7). The facility reported a census of 31 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool dated 6/12/20, Resident #7 had a BIMS score of 9 out of 15 indicating moderate cognitive deficit. According to the MDS dated [DATE], the resident had a BIMS score of 3 out of 15 indicating severe cognitive impairment. The MDS documented the resident required extensive assist of 1 staff for bed mobility and ambulation (walking), and was totally dependent on one staff for transfers, dressing, personal hygiene and toilet use. The MDS upon admission documented the resident required extensive assistance for transfers. The MDS revealed Resident #7 admitted on [DATE] with [DIAGNOSES REDACTED]. The care plan dated 6/15/20 for Resident #7 revealed he was at risk for falls, demonstrated severe cognitive impairment, and had chronic pain with arthritis in his hip. The care plan noted he had severe dementia that caused communication problems including difficulty understanding and being understood by others. The care plan documented he could be demanding and would often put himself on the floor. In a telephone interview on 8/18/20 at 11:45 AM, a member of the community reported that some time at the end of May, 2020 a staff member had shown him/her a picture on their phone of a resident at the facility. The staff person told the community member the picture of the male resident had been taken in the last day or two. The community member described the photo: it had been taken when it was dark outside and showed a heavy-set person on their hands and knees on a sidewalk with the resident's back side visible and covered with feces. The community member reported the staff person did not disclose the name of the resident in the picture, but did say he had exited the building without staff knowledge and added it was because all of the staff working that night were helping other residents and had not heard the door alarm. The staff person told the community member the Director of Nursing (DON) knew the resident exited that night, but told the staff not to talk about it because she didn't want the administrator to know he had gotten out. When asked in an interview on 8/18/20 at 1:00 PM, the DON reported the facility did not have any elopements in the previous 6 months and she did not have any incident reports related to attempted elopements. Resident #7's nursing notes revealed the following entries: A. An late entry on 3/19/20 at 5:27 documented on 3/18/20 at 6:00 PM resident crawling on the floor. When approached by staff he said he was leaving. When staff attempted to redirect him he became physically aggressive. B. On 3/21/20 at 7:00 PM, staff wrote resident crawling on the floor in the dining room and grabbing at other residents' legs. C. On 3/22/20 at 12:04 AM, staff found the resident in his room, naked, with urine all over the floor. D. On 4/5/20 at 2:35 PM, staff identified the resident had been crawling on the floor. E. On 4/21/20 at 4:49 PM, the resident kept lowering himself to the floor and was difficult to assist back to his chair. G. On 5/18/20 at 2:06 PM, staff documented the resident repeatedly stood up from his chair without assistance. H. On 5/19/20 at 2:30 AM, the resident crawled up and down the hallways until staff could successfully redirect him to bed. Later, staff found him on the floor in his room with the resident and the floor covered in feces. I. A late entry on 5/23/20 at 8:51 AM. documented by the overnight nurse nurse on 5/22/20 revealed the resident had been sliding out of his chair and then later crawled out of bed. He then removed his incontinence brief and then proceeded to crawl up and down the hallways. Staff were not able to redirect him. In an interview on 8/20/20 2:10 PM, Staff R, Certified Nursing Assistant (CNA) confirmed she had worked the overnight shifts (6 PM-6 AM) at the facility for approximately a year. When asked about Resident #7 and his exit seeking behaviors, she reported over the 8/16/20 weekend she had worked when he opened the door and tried to exit several times. The DON then asked her to put an alarm on him. When asked if he had gotten outside the building on the night of 5/22/20 when she worked. Staff R acknowledged she had found Resident #7 in the fenced courtyard around the side of the building that night. She said he had been naked from the waist down on all fours, crawling on the sidewalk with feces on him. She added that this must have been when he stubbed his toe, an injury that the nurses had started treating several days later. Staff R said the resident would often put himself on the floor and crawl up and down

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F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) the hallways. When asked if the DON had knowledge of this incident, she reported Staff L, RN had called the DON immediately after it happened but she had no knowledge of their conversation. Review of the nurses notes revealed the chart lacked any documentation that verified Resident #7 exited the building on 5/22/20. When asked in a conversation on 8/20/20 at 9:00 AM, the DON stated she had worked during the weekend of 8/16/20 and reported Resident #7 had approached the door on two occasions and opened it, but did not exit the building and was always within the line of sight of staff. She reported there were no incident reports or facility reported (to the Department of Inspections and Appeals) incidents regarding Resident #7. When asked in a follow-up interview on 8/24/20 9:09 AM, Staff R, CNA, stated she did not know how long Resident #7 had been outside and she said she really couldn't say for sure as she and Staff E, CNA, and Staff L, RN had been attending to two residents down the 100 hall for some time. She reported when she and Staff E went back toward the nurse's station they heard the alarm going off. She added that all of the staff carry their cell phones to communicate with other staff because they do not have Walkie-Talkies at the facility. In an interview on 8/24/20 at 1:15 PM, Staff E, CNA remembered she worked a double shift on 5/22/20 and had clocked out at 2 AM on 5/23/20. She recalled Resident #7 had exited through the back door while she and Staff R were down the 100 hall. She said they did not hear the alarm until they got closer to the nurses station. She said they found Resident #7 crawling around in the court yard and he was trying to get away because he thought we were the cops. She reported they had played along and asked him to surrender. Staff E added they were told by the DON not to talk about the incident because she did not want the administrator to know Resident #7 had been outside. In a subsequent interview on 8/25/20 at 12:45 PM, Staff E, CNA reported the DON had been at the front door waiting for someone to open it just after they had gotten Resident #7 back into his room. When she went to open the door for the DON she told her what they had been doing. Staff E denied any knowledge of anyone taking a picture of the resident while he was outside. She reported all staff carry their cell phones because it's their main means of communication throughout the building when they are working. In a follow-up interview on 9/1/20 at 2:00 PM Staff E, CNA stated both the DON and Staff L, RN had attended to Resident #7 on 5/22/20 after staff had returned him to his room. She remembered as she walked down the 200 hall to help Staff R locate the resident, the floor in the hallway had been smeared with feces. Staff E agreed to display the pictures on her phone from the month of May. Staff E's phone did not contain any pictures of residents. In an interview on 8/20/20 4:00 PM, Staff L, RN stated that she had no knowledge of any residents exiting the building on any of the overnight shifts she had worked. When asked if she remembered the weekend of 5/22/20, she said nothing came to mind. When asked specifically about Resident #7 exiting the building and found by staff in the court yard, she denied any knowledge of this and added that she was always on the move; if it did happen, the CNA's probably took care of it themselves. Staff L was then asked if she remembered working with Staff E because it was unusual for Staff E to work an overnight shift. Staff L then said she was beginning to remember that night because they had two residents they had been dealing with; one with blood in his catheter and one with an elevated temperature. She reported she had called the DON regarding the two residents and the DON had come in to help, but again denied having knowledge of Resident #7 exiting the building. When asked about the injury to the resident's toe, she stated he likes to crawl on the floor and up and down the hallways and that was probably how he injured it. A review of the chart revealed an initial wound assessment documented on 5/25/20 at 5: 51 p.m. that identified a new skin tear on Resident #7's left toe. When asked in an interview on 8/24/20 at 1:00 PM, about having to come to the facility in the middle of the night to assist with residents, she verified she came in to assist, but could not remember what time of night it had been. She denied having any knowledge of Resident #7 getting out of the building that night, and added she was shocked because she had just learned about this incident after Staff R told her about being interviewed regarding the occurrence during the investigation. The DON stated she did she not recall if she had even seen or talked to either of the CNA's that night because she and the RN were busy with the two residents down the 100 hall. She reported she thought she was only at the facility for 45-60 minutes and the RN did not say anything to her about Resident #7 exiting the building. In an interview on 8/26/20 at 7:30 AM, Staff P, Certified Med Aide (CMA) said she remembered working Memorial Day weekend. Staff P recalled she clocked in at 2:00 AM on 5/23/20, replacing Staff E for the night. She said there wasn't anything different about that night, and she could not think of anything that stood out to her. She recalled she entered the facility just as the DON was leaving and no mention was made regarding Resident #7 exiting the building without staff knowledge. She also reported Staff E did not say anything about it shift report. Staff P maintained that Resident #7 was in his bed when she came on shift and she thought he had stayed there the rest of the night. When directed to the nursing documentation that showed the resident had been very restless that night and would not stay in his bed, she denied any recollection of those events. The nurse's notes contained an entry written on 5/23/20 at 8:51 AM by Staff L that revealed the resident had been restless and was on 30 minute checks because he had crawled out of bed. The note also documented the resident removed his incontinence brief and crawled up and down the hallway. Staff were unable to redirect him and he would not stay in bed, so the CNA dressed him and he sat in the TV room. In a follow-up interview on 9/10/20 at 6:16 PM with Staff L, RN she stated that after a recent conversation with the DON, she reminded her that she had actually gone outside and assisted the CNA's with Resident #7 when he exited on 5/22/20. She said that once he was back inside she assessed him for any injuries and did not find any concerns. She stead until April, they would have two nurses on the overnight shift and since that time she's felt overwhelmed being the only nurse on that shift. Staff L said she didn't know why she hadn't documented that the resident had gotten outside but she was probably in a hurry to clock out because she had been was pressured from the administrator to get her charting completed in a timely manner. Staff L also denied recalling a conversation with the DON regarding Resident #7 that night. When asked about the injury to the resident's toe she said she thought staff had been treating the toe prior to this occurrence. Staff L reported the resident had been incontinent of bowel because she found feces smeared on a Hoyer lift that stood just outside the resident's bedroom, but denied knowledge of pictures taken by anyone. In a follow up interview on 9/16/20 at 5:50 PM Staff R, CNA verified the RN had gone outside to help them with Resident #7 after he exited. She reported that Staff L helped them assist him up from the sidewalk and she and Staff E assisted him to his room where the RN assessed him. Staff then washed him up and assisted him to bed and he stayed there the rest of the night. She said she didn't know where the DON had been at that time because she had no contact with her that night and thought. She then said that the elopement happened after the DON had left that night. Staff R agreed to show the pictures on her phone from the month of May and there were no pictures of residents on the phone. In an interview on 9/14/20 at 9:30 AM, the administrator (who had just started in the position the previous week) reported there was a pile of Walkie-Talkies in the office that were not in use. The DON stated that shortly after the facility purchased those, the staff had refused to use them because they preferred to use their cell phones for communication around the building. An undated facility policy out of the employee handbook, page 36, contained a paragraph titled Personal Cell Phones which directed staff that the use of personal cell phones while on duty is prohibited. Use of personal cell phones is limited to breaks and meal periods. Employees may not initiate or receive calls or text messages while caring for a resident. If the facility determines that an employee engages in personal cell phone/texting use during work hours, he or she may be subject to disciplinary action.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to verify they took appropriate corrective action related to alleged abuse and failed to protect and separate the alleged victim from the alleged perpetrator during an ongoing investigation (Resident #7). The facility reported a census of 31 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool dated June 12, 2020, Resident #7 had a BIMS score of 9 out of 15 indicating he demonstrated moderate cognitive deficits. According to the MDS dated [DATE], the resident had a BIMS score of 3 out of a possible 15 indicating severe cognitive impairment. The MDS documented the resident required extensive assist of 1 staff for bed mobility and ambulation (walking), and was totally dependent on one staff for transfers, dressing, personal hygiene and toilet use. The care plan dated 6/15/20 for Resident #7 revealed he was at risk for falls, demonstrated severe cognitive impairment and had chronic pain with arthritis in his hip. The care plan indicated that he had severe dementia that caused communication problems including difficulty understanding and being understood by others. The care plan documented he could be demanding and would often put himself on the floor. In a telephone interview on 8/18/20 at 11:45 AM, a member of the community reported that some time at the end of May, 2020 a staff member had shown him/her a picture on their phone of a resident at the facility. The staff person told the community member the picture of the male resident had been taken in the last day or two. The community member described the photo: it had been taken when it was dark outside and showed a heavy-set person on their hands and knees on a sidewalk with the resident's back side visible and covered with feces. The community member reported the staff person did not disclose the name of the resident in the picture, but did say

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) he had exited the building without staff knowledge and added it was because all of the staff working that night were helping other residents and had not heard the door alarm. The staff person told the community member the Director of Nursing (DON) knew the resident exited that night, but told the staff not to talk about it because she didn't want the administrator to know he had gotten out. On 8/31/20 at 3:15 PM, notification to the facility occurred of the community member's abuse allegation (detailed in the paragraph above) related to Resident #7. The facility management were directed to initiate an abuse investigation. A disciplinary action form dated 8/31/20 at 3:25 PM revealed the Director of Nursing (DON) and Nurse Consultant (NC) told the alleged perpetrator (Staff E) to leave the premises. Documentation showed they also suspended Staff E pending investigation. A review of the incident investigation conducted by the DON and NC revealed they they found no evidence that showed Staff E took a picture that showed Resident #7 crawling on the ground outside, naked, and covered with feces. According to the report, the Certified Nursing Assistant (CNA) and Registered Nurse (RN) that worked with Staff E on 5/22/20 were interviewed along with the CNA that reported to work on the morning of 5/23/20. In a phone interview on 9/1/20 at 8:40 AM, Staff E verified she remained off work and had not yet been interviewed by anyone at the facility related to the investigation. During an interview on 9/2/20 at 11:30 AM, when encouraged to review the regulations regarding abuse investigations, the DON verbalized understanding of the regulation and stated the facility had no intention of allowing Staff E to return to work while the investigation was ongoing. Observation on 9/10/20 at 10:00 AM, revealed Staff E, CNA present at the facility and working with residents. Review of the facility Shower Sheets revealed Staff E gave Resident #7 a shower on 9/11/20 with Staff Q present. On 9/15/20 at 11:33 AM, in a telephone interview, Staff Q reported she had assisted with Resident #7's shower. When asked, she recalled she may have left the shower room briefly to get some socks for the resident. On 9/15/20 at 12:08 PM, in a telephone interview, Staff E reported she returned to work on 9/9/20. When asked about any resident contact restrictions imposed, she reported the DON just told her the day before that she could not have contact with Resident #7 until the investigation was completed. In an interview on 9/15/20 at 12:23 PM, the DON reported she called Staff E to notify her she could return to work but could not have contact with Resident #7 until after the investigation, but she did not have any documentation related to restriction agreements. On 9/16/20 at 6:00 PM, the NC reported she had interviewed Staff E on 8/31/20 at 3:25 PM with the DON and Human Resources staff present and they had asked to see the pictures on her phone. The NC added they did not see any appropriate photos on the phone.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete and update comprehensive care plans for 4 of 19 residents reviewed (Residents #7, #15, #18, & #19) . The facility reported a census of 31 residents. Findings include: 1) The Minimum Date Set (MDS) assessment tool dated 3/24/20 documented Resident #7 scored 3/15 on the Brief Interview for Mental Status (BIMS) test, which meant he displayed severe cognitive impairment. According to the MDS dated [DATE], Resident #7 had a BIMS score of 9 (moderate cognitive impairment). The MDS dated [DATE] documented the resident required extensive assist of one staff for bed mobility and walking and remained totally dependent on one staff for transfers, dressing, personal hygiene and toilet use. The MDS dated [DATE] revealed Resident #7 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS documented he required extensive assist of 1 staff for transfers. According to the nursing notes, the resident was very aggressive toward staff and often required 15 and 30 minute checks due to unpredictable behaviors. The resident's care plan dated 6/15/20 documented he was at risk for falls, had severe dementia, displayed severe cognitive impairment, and chronic pain with arthritis in his hip. The care plan revealed he had difficulty understanding others and being understood, engaged in unreasonable and demanding behaviors and would often put himself on the floor. In an interview with the Director of Nursing (DON) on 8/20/20 at 9:00 AM, she reported the resident pushed the door open and tried to leave on two occasions on 8/16/20, and after the second attempt she had a monitor put on his ankle to alarm if/when he got close to the doors. On 9/16/20, review of the care plan revealed no documentation regarding exit seeking behaviors or the ankle monitor. 2) According to the MDS assessment tool dated 8/7/20, Resident #15 had a [DIAGNOSES REDACTED]. The MDS documented the resident had a BIMS score of 15 out of 15 (intact cognitive status) and was totally dependent on 2 staff with transfers, dressing, toilet use, and bed mobility. According to the electronic record census page Resident #15 was admitted to the facility on [DATE] and had 6 hospitalization s throughout his stay. The care plan last updated on 5/5/20 revealed the resident had altered respiratory status, difficulty breathing, a [MEDICAL CONDITION], a potential for altered nutritional status related to bolus tube feeding and had experienced a spinal cord injury. The care plan documented the resident he had actual skin impairment and directed staff to measure the areas per facility guidelines with weekly skin assessment and to provide treatments to wounds according to the physician orders. The care plan also documented the resident took anticoagulant medication which put him at risk for abnormal bleeding and had an indwelling catheter with a staff directive to change the catheter per physician orders. On 8/23/20, Resident #15 admitted to the hospital with [REDACTED]. The care plan was not reinstated until 9/8/20 after it was brought to the facility's attention, which resulted in the resident having no active or baseline care plan upon readmission. In an interview with the Director of Nursing on 9/10/20 at 3:00 PM she said she did not know why the care plan had been canceled and that this was done from the corporate office. In an interview on 9/14/20 at 9:50 AM, the nurse consultant said that at the time of the resident's hospitalization the MDS had been entered as return to facility not expected, which caused the software to automatically cancel out the care plan. 3) According to MDS dated [DATE], Resident #19 admitted on [DATE] with [DIAGNOSES REDACTED]. The MDS revealed the resident had a BIMS of 4/15 (severe cognitive deficit), required extensive assist of 2 staff for transfers and toilet use. The care plan dated 7/22/20 indicated that the resident required assistance with activities of daily living due to confusion, weakness and impaired vision, and was at risk for nutrition problems. According to the physician's orders [REDACTED]. The care plan did not contain interventions or staff directives to assist, treat, or mitigate the identified nutritional problems or the pressure ulcers. 4) According to the MDS dated [DATE], Resident #18 had [DIAGNOSES REDACTED]. The MDS documented a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident displayed intact cognitive abilities. The MDS documented the resident required extensive assist of 1 staff for transfers, dressing, toilet use, and bed mobility. According to the electronic record under the census tab, Resident #18 admitted to the facility on [DATE], transitioned to Hospice services on 8/8/20, and passed away on 8/11/20. Review of the Iowa Physician order [REDACTED].) Resident #18's care plan dated 6/22/20 documented the resident had requested a full code status, but did not include an update to include the 8/12/20 DNR order.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews the facility failed to provide necessary services to maintain personal grooming and hygiene for 5 of 5 residents reviewed for bathing (Residents #4, #6, #9, #12 & #13). The facility reported a census of 31 residents. Findings include: 1. According to the annual Minimum Data Set (MDS) assessment tool dated 6/29/20, Resident #4 had [DIAGNOSES REDACTED]. The MDS listed a Brief Interview for Mental Status of 14/15 which indicated he displayed intact cognitive abilities. The MDS documented the resident as independent with transfers, dressing and toilet use, set-up help with supervision for eating, and minimal assist of 1 staff for his bath. The Care Plan dated 7/1/20 revealed Resident #4 required assistance with nail hygiene and bathing due to diabetes, dementia and [MEDICAL CONDITION]. The Care Plan directed staff to provide a bath 2 times a week and have the charge nurse check and trim nail length on bath day. Review of the facility form Skin Monitoring: Comprehensive Shower Review revealed no documentation to show the resident had a bath during the weeks of 6/29/20, 7/27/20, and 8/3/20. During an observation on 8/4/20 at 10:40 AM, Resident #4 lay on the on the bed in his room with no bottom sheet under him. He was wrapped in a top sheet with the sheet around his head and had long fingernails with dirt under them. The room had a strong urine odor. 2. According to the quarterly MDS dated [DATE], Resident #6 had [DIAGNOSES REDACTED]. The MDS documented a BIMS score of 12/15, indicating he demonstrated moderately impaired cognition. The MDS also coded him as independent with bed mobility, transfers, dressing, and toilet use and and requiring minimal assist of 1 staff for bathing. The Care Plan dated 6/26/20 for Resident #6 revealed he required assist of 1 for bathing 2 times per week due to an activity intolerance and impaired balance. Review

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) of the facility form Skin Monitoring: Comprehensive Shower Review revealed Resident #6 revealed no documentation to show the resident had a bath during the weeks of 6/29/20, 7/6/20, 7/13/20, 7/27/20, and 8/3/20. During an observation on 8/4/20 at 3:30 PM, Resident #6 had long nails with dirt present under them. 3. According to the quarterly MDS dated [DATE], Resident #9 had [DIAGNOSES REDACTED]. The MDS documented a BIMS score of 10/15, indicating she demonstrated moderately impaired cognition. The MDS revealed the resident required extensive assist of 1 staff for transfers, dressing, toilet use, and bathing. The Care Plan dated 6/22/20 revealed she required assist of 1 staff for bathing 2 times per week due to chronic arthritic pain and history of a stroke. Review of the facility form Skin Monitoring: Comprehensive Shower Review revealed revealed no documentation to show Resident #9 had a bath during the weeks of 6/19/20 and 6/26/20; and no bath documentation at all for the full month of July 2020. During an interview on 8/13/20 at 1:55 PM, the Director of Nursing stated could find no bath documentation for Residents #4, #6, and #9 other than than what she had already provided. She added the rest of the bath documentation for the 3 residents was missing and so she could not confirm whether or not staff provided baths for them. When asked, she replied she expected staff to complete the residents' baths when scheduled unless the resident refused them. 4) According to the MDS dated [DATE], Resident #13 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS listed a BIMS score of 11/15, which meant he displayed moderate cognitive impairment. The MDS documented the resident as independent with transfers, ambulation (walking), dressing, and toilet use. Review of the care plan last updated on 6/5/20 revealed Resident #13 as at risk for falls due to impulsivity and poor insight and the potential for pain related to [DIAGNOSES REDACTED]. The care plan documented the resident as at risk for self-care performance deficit. A review of the electronic and paper documentation provided by the facility revealed that the resident received only two showers in the month of July. The nursing notes failed to contain documentation to show how often staff offered the resident a shower or if he had refused any bathing opportunities. 5) According to the MDS dated [DATE], Resident #12 had a BIMS score of 15 out of 15, indicating intact cognitive ability. The MDS indicated that the resident required some supervision with set up only for transfers and ambulation. According to the MDS, he required extensive assistance with the help of one person for dressing and was totally dependent with one person assist for eating. According to the MDS he readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan last updated on 5/1/20 for Resident #12 documented a potential for pain related to [DIAGNOSES REDACTED], was dependent on a ventilator at night and had a [MEDICAL CONDITION] related to [MEDICAL CONDITION]. In an observation on 8/17/20 at 11:10 AM, Resident #12 walked in the hallway with the assistance of a walker. When asked if he had been offered a bath or shower on a regular basis he said that he was offered about once a week but that he would like to get a shower at least twice a week. In an interview with Staff J on 8/17/20 at 12:45 PM Staff J said staff document baths and showers on paper as they are completed and then scanned into the electronic chart. The chart lacked documentation of a shower or bath for Resident #13 in the months of July or August.
F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide consistent and adequate wound care to prevent the development and worsening of pressure sores, and failed to provide sufficient wound assessments and documentation for 1 of 1 residents reviewed (Resident #15) for wound care. Resident #15 admitted to the facility on [DATE] and had been admitted to the hospital a total of 6 times during his stay. The resident had [DIAGNOSES REDACTED]. The resident's care plan dated 5/5/20 identified he had altered skin integrity (open areas) and listed intervention that directed staff with regard to his care. The resident's record showed staff failed to measure, assess and document wounds on a consistent basis and also did not always complete wound and pressure sore treatments on a regular basis. As a result, new wounds developed and the resident's existing wounds showed an increase in size. The facility reported a census of 31 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment tool dated 8/7/20, Resident #15 had [DIAGNOSES REDACTED]. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) test score of 15/15 which meant the resident demonstrated intact cognitive abilities. The MDS also documented the resident as totally dependent on 2 staff for transfers, dressing, toilet use, and bed mobility. According to the census page in the electronic record, Resident #15 admitted to the facility on [DATE] and had been transferred to the hospital 6 times during his stay. A care plan last updated on 5/5/20 documented Resident #15 experienced altered respiratory status and difficulty breathing. The care plan also identified the resident had a [MEDICAL CONDITION]. The care plan revealed a potential for altered nutritional status related to bolus tube feeding and a [DIAGNOSES REDACTED]. According to the care plan, Resident #15 also had a problem with impaired skin integrity and staff were directed to measure the areas according to facility guidelines with weekly skin assessments and to provide treatments to wounds according to the physician orders. The care plan documented he took anticoagulant medication, which put him at risk for abnormal bleeding, and also documented he utilized an indwelling catheter for urination. The care plan directed staff to change the catheter according to the physician orders. According to a report from the hospital dated 8/23/20, Resident #15 presented to the emergency roiagnom on [DATE] at 8:57 AM with scrotal bleeding and underwent emergency surgery at that time to repair a torn urethra caused by improper placement of a urinary catheter. The nursing notes documented the resident returned to the facility on [DATE]. A review of the clinical record revealed physician orders [REDACTED]. 2) On 6/20/20: Clean right buttock open area and apply zinc oxide twice daily. 3) On 6/20/20: Clean sacral area and apply zinc oxide twice daily. 4) On 6/20/20: Moisten gauze with sterile water, pack right hip, and cover with bordered foam twice daily. 5) On 6/20/20: Moisten gauze with Dakins Solution, pack right buttock wound bed, and cover with bordered foam twice daily. 6) On 6/20/20: Moisten gauze with Dakin's solution, pack sacral wound, and cover with bordered foam twice daily. 7) On 6/20/20: Clean PEG tube site, apply zinc oxide to area, and apply 4 x 4 twice daily. 8) On 4/07/20: Apply [MEDICATION NAME] twice daily. 9) On 4/15/20: Ensure heel protectors remain on at all times wound prevention twice daily. 10) On 5/20/20: Apply skin prep to right heel, apply [MEDICATION NAME], and wrap with kerlix once daily. 11) On 7/15/20: Cleanse right heel, apply Dermesyn, and cover with foam daily. According to a hard copy of the Treatment Administration Record (TAR), staff failed to complete the following treatments in the months of June and July of 2020: Order #1 began on 6/21/20 and staff missed it 8 times in June and 15 times in the month of July. Order #2 began on 6/21/20 and staff missed it 8 times in June, and 14 times in July. Order #3 began on 6/21/20 and staff missed it 8 times in June and 14 times in July. Order #4 began on 6/21/20 and staff missed it 8 times in June and 22 times in July. Order #5 began on 6/21/20 and staff missed it 8 times in June and 21 times in July. Order #6 began on 6/21/20 and staff missed it 8 times in June and 20 times in July. Order #7 began on 6/21/20 and staff missed it 4 times in June and 13 times in July. Order #8 began on 4/7/20 and staff missed it 15 times in June and 14 times in July. Order #9 began on 4/15/20 and staff missed 15 times in June and 14 times in July. Order #10 began on 5/20/20 and staff missed it 7 times in June (order discontinued in July). Order #11 began on 7/15/20 and staff missed it 5 times in July. A review of the skin assessments in the medical chart revealed from 6/23/20 through 8/11/20, the chart included only 8 documents that contained only this narrative: weekly skin assessment completed and no new skin concerns noted. A review of the medical chart revealed: a. A wound assessment dated [DATE] that detailed wound location with corresponding measurements: Site 25) Right hip: 1 centimeter (cm) length (L) x 0.6 cm width (W) x 2.2 cm depth (D). Site 53) Sacrum: 1 cm (L) x 1 cm (W) x 2.5 cm (D) Site 55) Right gluteal fold: 1 cm (L) x 0.6 cm (W) x 2.2 cm (D) Site 49) Right heel: 1 cm (L) x 1 cm (W) x 0.0 (D) b. The next wound assessment dated [DATE] that listed wound locations with corresponding measurements: Site 53) Sacrum: 1 cm (L) x 1 cm (W) x 0.1 cm (D) Site 31) Right buttock: 2 cm (L) x 0.7 cm (W) x 0.1 cm (D) Site 36) Left thigh: 2.5 cm (L) x 1.7 cm (W) x 0.1 cm (D) Site 14) Abdomen 4 cm (L) x 4 cm (W) x 0.1 cm (D) c. A would assessment on 8/18/20 listed the following sites, but did not contain any measurements: Site 53) Sacrum Site 49) R heal Site 50) L heal Site 55) R gluteal fold Site 25) R trochanter hip A review of the documentation revealed that the assessment on 6/20 and 8/18 had only one wound site in common (sacrum) According to the hospital report dated 8/24/20 a wound care specialist saw the resident while at the hospital. The wound report included 11 sites, including the surgical wound on the scrotum. The following four sites were listed on the hospital report but were not included in any of the facilities reports: 1) Left lateral foot: 1.5 cm (L) x 1.5 cm (W) x 0.1 cm (D) 2) Right ischium: 1 cm (L) x 1 cm (W) x 3 cm (D) 3) Left gluteal cleft: 0.5 cm (L) x 0.5 cm (W) x 0.1 cm (D) 4) Right lateral foot: 0.3 cm (L) x 0.3 cm (W) x 0.1 cm (D) Due to incomplete charting the only area that could be determined as the same sight measured and recorded at both the hospital and at the facility (Site 25 Right trochanter hip) measured 1 cm x (L) 0.6 cm (W) x 2.2 (D) on 6/2/20 and at the hospital it measured 2 cm (L) x 1.5 cm (W) x 0.1 cm (D). A review of the chart revealed many of Resident #15's wound assessments lacked measurements. In an interview on 8/25/20 at 2:20 PM, the DON stated she documented the wound measurements on a flash drive and sent them to the corporate office on a

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	165230	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

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F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 4) weekly basis, but reported the flash drive with the wound documentation was at home. In an interview on 8/27/20 at 11:35 AM, the wound specialist from the hospital stated he was familiar with the resident and understood that Resident #15 had some chronic wounds that are problematic. He said he noticed some new wounds, several of which were pressure sores during the resident's most recent hospitalization . He added it would be important to continue treatments as ordered, reposition the resident frequently, and ensure protective devices remained in the wheel chair and on the heels. In an interview on 9/14/20 at 9:45 AM the nurse consultant acknowledged that wound care has been a challenge at the facility. The nurse consultant stated they had started working on utilizing the wound specialist to attend to residents' high level wounds.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide adequate nursing supervision to keep residents free from accidents and hazards for 1 of 19 residents reviewed (Resident #7). The facility reported a census of 31 residents. Findings include: According to the MDS completed upon admission and dated 3/24/20, Resident #7 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS documented a BIMS score of 3/15, which identified the resident displayed severe cognitive impairment. The MDS revealed the resident required extensive assist of 1 staff for transfers. According to the Minimum Data Set (MDS) assessment tool dated 6/12/20, Resident #7 scored 9/15 on the Brief Interview for Mental Status (BIMS), which identified the resident displayed moderate cognitive impairment. The MDS documented the resident required extensive assist of one staff for bed mobility and ambulation (walking) and was totally dependent on one staff for transfers, dressing, personal hygiene, and toilet use. The nurse's notes contained documentation that described very aggressive behavior toward staff and revealed the facility often had him on 15 minute and 30 minute checks due to unpredictable behaviors. According to the resident's care plan dated 6/15/20, Resident #7 was at risk for falls with severe cognitive impairment and chronic pain with arthritis in his hip. The care plan indicated that he had severe dementia that resulted in difficulty understanding others and being understood. The care plan documented the resident had unreasonable and demanding behaviors and would often put himself on the floor. When asked in an interview on 8/18/20 at 10:00 AM if the facility had any elopements (residents leaving the facility without staff knowledge or permission), the Director of Nursing (DON) reported there were none. In an interview on 8/20/20 at 2:10 PM, Staff R Certified Nursing Assistant (CNA) verified Resident #7 had exited the building on 5/22/20 when she worked the overnight shift. She reported she and Staff E, CNA had been assisting the nurse with two other residents on the 100 hall and did not hear the door alarm sound when the resident exited. Staff R stated that when they left rooms [ROOM NUMBERS] and walked closer to the nurse's station, they could then hear the door alarm. She reported they found Resident #7 crawling on the sidewalk outside, and she thought that this might have been when he injured his toe. A Skin assessment dated [DATE] documented staff found a new skin tear on the resident's left middle toe. In a follow up interview on 8/20/20 at 9:30 AM, when asked again about any residents getting out of the building, the DON named Resident #7. She reported Resident #7 had attempted to elope twice over the weekend of 8/16/20 he had not gotten out of the staff's line of sight. She reported no incident reports had been completed for these attempted elopements, but they did put an ankle alarm on him after these events. She denied having any knowledge of Resident #7 eloping on 5/22/20 in the middle of the night. In an interview on 8/24/20 at 1:15 PM Staff E ,CNA reported the night Resident #7 had exited, she and Staff R, CNA had been on the 100 hall and had not heard the alarm. As they came down the hall closer to the nurse's station, they realized the alarm had sounded and went to find the person that had exited the building. Staff E said they found Resident #7 had exited into the courtyard and saw him crawling on the ground. She reported the RN and the DON were aware of the incident, but the DON had instructed them not to talk about it because she didn't want the administrator to know. In an interview on 8/20/20 at 4:00 PM Staff L, RN stated she had no knowledge of any residents exiting the building on any of the overnight shifts that she worked. When asked specifically if Resident #7 had exited into the courtyard on 5/22/20, she denied any knowledge of the occurrence and added if it had happened, the CNA's probably took care of it themselves. In a follow up interview with Staff L, RN on 9/10/20 at 6:16 PM, she reported she had gone outside to assist the CNAs to assist Resident #7 off the ground and then assessed him for injuries once he was back in his room. She verified she had not completed an incident report or written a nursing note about this event. She said that she was probably in a hurry because she had been getting a lot of pressure from the administrator to get her documentation completed in a more timely manner. On 8/26/20 at 9:30 AM, observation revealed when Staff AA, maintenance opened the door (upon request) at the end of the 300 hallway that exited to the parking lot, the alarm could not be heard while standing in rooms [ROOM NUMBERS] that were located at the end of the 100 hall. The alarm also could not be heard at the end of 200 hall. In an interview with the DON, she verified the observation as she had been present also. In an interview on 8/26/20 at 1:00 PM, the nurse consultant and DON acknowledged a challenge with the system and arranged for a company to come on 8/27/20 to add extenders to the alarm system to amplify the alarms to all the hallways.
F 0690 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the required nursing services for urinary catheter care to prevent complications for 4 of 4 residents reviewed for catheter cares (Resident #15, #18, #16, & 17). The facility failed to obtain catheter orders for routine catheter care, failed to assess and intervene when abnormal signs/symptoms of urinary function presented, and failed to properly insert a catheter which caused a torn urethra that required surgical repair (Resident #15). The resident presented to the hospital with [MEDICAL CONDITION] with septic shock (complication of infection in the blood), scrotal abscess, acute blood loss, and sacral decubitus (pressure sore). The facility reported a census of 31 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment tool dated August 7, 2020, Resident #15 had [DIAGNOSES REDACTED]. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 15/15, which meant the resident demonstrated intact cognitive abilities. The MDS documented the resident as totally dependent on 2 staff for transfers, dressing, and toilet use. According to the electronic record census page, Resident #15 was admitted to the facility on [DATE] and had 6 hospitalization s throughout his stay. The care plan last updated on 5/5/20 indicated that the resident had altered respiratory status, difficulty breathing and had a [MEDICAL CONDITION]. The care plan stated that he had potential for altered nutritional status related to bolus tube feeding and was paraplegic related to a spinal injury, with no feeling from the nipples down. The care plan indicated that he had actual skin impairment and staff were directed to measure areas per facility guidelines with weekly skin assessment and to provide treatments to wounds according to the physician's orders [REDACTED].#15 was on anticoagulant medication which put him at risk for abnormal bleeding and had an indwelling catheter. The care plan directed staff to change the catheter according to physician's orders [REDACTED].#15 presented at the emergency roiagnom on [DATE] at 8:57 AM with scrotal bleeding. The hospital report documented the nursing home reported the bleeding started on 8/22/20. The hospital record contained a (CT) scan completed at the hospital that revealed malposition of the urinary catheter. The catheter balloon had been inflated in the urethra (rather than in the bladder), which caused the urethra to tear. Further review of the hospital record showed a cystoscopy (a procedure that allows the physician to examine the lining of the bladder and urethra - the tube that carries urine out of the body - with a hollow tube called a cystoscope. The scope is equipped with a lens that is inserted into the urethra and slowly advanced into the bladder) was completed to evaluate the urethral injury and evacuate any clots. Then, emergency surgery was performed to repair the urethral tear. The hospital assessment listed the presenting problems as follows: [MEDICAL CONDITION] with septic shock, scrotal abscess, acute blood loss and sacral decubitus (pressure) ulcer of the sacral region. In an interview on 8/31/20 at 8:30 AM the urologist that performed Resident #15's emergency stated due to where the new catheter balloon had been inflated, the resident would have had some urinary output and may have had leakage around the catheter site. With proper placement in a male, a catheter will protrude approximately 6 inches; if it had been misplaced, staff should have noticed more of the catheter had been exposed than normal. The doctor reported that within a couple of hours of misplacement, he would have expected bladder spasms and leakage to occur. The doctor added he would have expected the nurse that inserted the catheter to have met with some resistance as the balloon was being inflated, and should have discontinued the procedure at that time. He said he typically

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F 0690 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) expected staff to change catheters about every 4 weeks and as needed. Resident #15's medical record revealed the most recent physician's orders [REDACTED]. On 8/25/20 at 6:30 PM, the Licensed Practical Nurse (LPN), Staff O, that had inserted Resident #15's urinary catheter documented a late entry into the electronic record and dated it as 8/19/20 at 10:06 AM. In the nursing note, Staff O, LPN charted a Certified Nursing Assistant (CNA) reported to her the resident's catheter had been leaking with very little urinary output, so she then inserted a new catheter. Staff O wrote she did not encounter resistance when she inflated the balloon and noted no problems or concerns regarding the resident's response to the catheter insertion. In an interview on 9/1/20 at 3:00 PM, Staff S, CNA stated she had been on vacation from 8/10 - 8/14/20 when she returned to work on 8/15/20 she learned the resident's catheter had been changed sometime while she was on vacation. She said she noticed swelling of the scrotum on Resident #15 on the 8/15/20 and reported it to a nurse at that time. The next time she worked was 8/18/20 and she noticed the swelling had doubled from when she saw it previously. She stated she reported it to the nurse, but did not know if there was follow-up at that time. On 9/2/20 at 11:15 AM Staff X, CNA verified she worked 8/14 - 8/16/20 and 8/19 - 8/20/20. She said she had provided catheter cares for Resident #15 on 8/14/20 and noticed a decrease in urine output and leaking of the catheter. She stated on 8/15/20, she noticed swelling and she reported it to Staff J, Assistant Director of Nursing (ADON). She added she did not know what type of, if any, assessments or measures the nurse took after she reported it to the nurse. In an interview on 9/1/20 at 1:00 PM, Staff P, Certified Med Aide (CMA) said she had been working with Staff T, CNA on an overnight shift when she noticed the resident displayed scrotal swelling and blood tinged urine. She stated she had reported it to a nurse, but did not remember which nurse it was or if there had been follow-up completed at that time. A review of the timesheets revealed that Staff P and Staff T worked together on the overnight shifts on 8/12 - 8/14/20 and 8/17/20. In an interview on 9/1/20 at 4:00 PM, Staff D, CNA said she was with Staff O, LPN when she inserted the resident's new catheter. She said she hadn't noticed if the LPN had any difficulty inserting the catheter but remembered there was a lot of urine output after the insertion. She also remembered she had worked the following day and at that time noticed swelling of the scrotum and reported it to Staff J, Assistant Director of Nursing (ADON). She recalled this was a weekend shift and the ADON directed her to keep an eye on it. Staff P reported she had a couple of days off, but the next time that she worked, the scrotum had swollen to twice the size. A review of the timesheets for August revealed Staff D and Staff O worked together on 8/10, 8/14, 8/16, and 8/19/20. Staff D worked with Staff J on 8/14 - 8/15/20. During a conversation on 9/1/20, Staff P, CMA determined the catheter must have been inserted on 8/14/20 and she noticed the swelling and reported it on 8/15/20. She then figured she came back to work on 8/19/20 and noted the swelling was much worse. In an interview on 9/2/20 at 8:30 AM with Staff O, LPN, she was asked to clarify her documentation dates. She was asked since she had entered the nursing note on 8/25 and dated it 8/19, could she have been mistaken about the date she inserted Resident #15's catheter? Staff O hesitated and said she remembered Staff D, CNA was with her and she was pretty sure it was the 8/19/20. Staff O reported she had inspected the catheter site after insertion and it had drained fine. She remembered that she worked on 8/21/20 and did not notice any concerns until at the end of her shift, when one of the CNA's reported to her the resident's scrotum was very swollen. She said that she had already clocked out, so she passed the information along to the night nurse, Staff L, RN. Staff O was informed the resident did not have an order for [REDACTED]. She said she decided what size of catheter to insert for Resident #15 from inspecting the size that he had in previously. When asked if Staff O could recall how much of the catheter may have been exposed after insertion, she said she thought it was about 3 inches. In an interview on 9/10/20 at 6:16 PM, Staff L, RN recalled the night that Resident #15 had gone to the hospital and commented it took over an hour for the ambulance to get to the facility that night. She stated she had been very concerned about the blood loss because they had changed the linens on the bed at least three times before the ambulance arrived around midnight. The resident record revealed a nurse's note had been entered into the electronic record on 8/26/20 and dated 8/22/20 at 2:00 PM. In the note, Staff J, ADON documented staff alerted her to Resident #15's scrotal bleeding and she assessed the area as hard and swollen with blood coming from an open area on the scrotum that measured 1 centimeter (cm) long by 1 cm wide. She reported she called the medical provider and was directed to call the urologist. Staff J then talked with the urologist on call that evening. She said he stated as long as the resident was stable through the night, she should arrange for him to be taken to the emergency room the next morning for an evaluation. A review of the clinical chart revealed the resident's vital signs on 8/22/20 at 3:00 PM were as follows: blood pressure: 96/47, heart rate: 92, temperature: 97.2, respirations: 18, and oxygen saturation: 96% on trach. In an interview on 9/1/20 at 4:22 PM, Staff J stated that the day before the resident had gone to the hospital she had assessed him earlier in the day and hadn't noticed any swelling, redness, and decrease in urine output. She said that later on 8/22/20 was the first that she became aware of swelling or bleeding because Staff W, CNA reported it to her. She said she called the urologist and he said that as long as his vitals were stable and the resident was not lethargic that they should arrange to get him in the next day. When asked about the routine for catheter changes, Staff J said that the night shift nurses would generally do them and the standard is every 30 days. When asked how she or anyone else would know when it was time to change the catheter if it was not listed on the Treatment Administration Record (TAR), she said she really did not have an answer to that question. When asked how the nurses know which size catheter to use if there is no order, she said they would look at the size of the catheter the resident had in at the time. Staff J reported stated that she had worked the weekend before the resident went to the hospital (8/14 - 8/15/20), nobody had come to her with concerns regarding swelling or blood in the catheter. She maintained the resident had no signs of infection and there was no reason to suspect misplacement of catheter. She added that until the day that the resident went to the hospital, his catheter was flushing just fine. When asked about nurse trainings and competencies, she said that DON does the trainings and she wasn't sure what was covered. In an interview on 8/31/20 at 2:55 PM Staff M, LPN said that she had worked at the facility for less than one year and hadn't ever changed a catheter for Resident #15. She said she did not have any training when she started at the facility and no competency skills checks had been completed for her. In an interview on 9/4/20 at 9:00 AM, the urologist confirmed the conversation that he had with Staff J on the evening of August 22nd. He had a note about the conversation and said that it had been reported to him the scrotal swelling was first noticed on Friday evening the 21st and by Saturday morning a small opening developed on the anterior scrotum. He said the nurse reported the resident's vitals had been stable and the nurse flushed the catheter a couple of times. The first time it flushed readily with a bit of blood, but on the second flush all of the fluid came out through the hole in the scrotum. He advised that as long as the resident was stable, they should get him in to the next morning. According to a nursing note, the resident transferred from the hospital and back to the facility on [DATE]. In an interview on 8/31/20 at 12:35 PM Resident #15 stated he understood he had been in the hospital for a torn urethra. When asked about his most recent catheter change at the facility he explained that he did not see what the nurses do when they change the catheter and since he has no feeling from mid-chest or below, he didn't know if anything unusual happened during insertion. He remembered that a couple of days after the insertion of the catheter an aide mentioned that she noticed he had some swelling and he had less urine output, but he did not remember which CNA said had told him or what date it had been. 2) According to an MDS dated [DATE], Resident #18 had [DIAGNOSES REDACTED]. The MDS showed a (BIMS) score of 15/ 15, which meant the resident demonstrated intact cognitive abilities. The MDS documented the resident required extensive assist of 1 staff for transfers, dressing, and toilet use and bed mobility. The census tab in the electronic record documented the resident admitted to the facility on [DATE], admitted to Hospice services on 8/8/20, and passed away on 8/11/20. The care plan for Resident #18 dated 6/22/20 documented the resident had a suprapubic catheter related to [MEDICAL CONDITION] of the prostate, [MEDICAL CONDITION] with [MEDICAL TREATMENT] treatment, and a history of [MEDICAL CONDITION] and kidney stones. The care plan directed staff to provide catheter cares as ordered. A hard copy of the Treatment Administration Record (TAR) documented an order dated 11/30/19 that directed staff to maintain a 22 French supra pubic catheter and to change it on the last day of the month. The April TAR for Resident #18 lacked documentation of a catheter change in the Month of April. According to a nursing notes, on 5/21/20 at 15:00, the resident complained of abdominal pain and staff reported that there was blood in the catheter bag. According to the nursing notes, the resident continued to have pain and blood in his urine over the following days. On 5/23/20 at 9:30 AM the doctor was called and the resident was admitted to the hospital with [REDACTED]. A review of the chart revealed staff changed his catheter on 6/30/20, but the July 2020 TAR lacked documentation of a catheter change in the month of July. Further review of the resident's record showed an order beginning 5/28/20 to irrigate the suprapubic catheter every day and night shift and to clean the supra pubic catheter every day and night shift. According to the census page in the electronic chart, the resident had been in the hospital 8 days in the month of July 2020. A review of the charting revealed staff missed an opportunity to irrigate the suprapubic catheter 20 times in June 2020 and 8 times in July 2020. Staff also missed the opportunity to clean the catheter 16 times in June and 7 times in July. 3) According to the MDS

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	165230	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

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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 0690 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 6) dated [DATE]th 2020, Resident #16, could not participate in the BIMS test and experienced severely impaired cognition. cit. The MDS revealed he was totally dependent on two staff for transfers, dressing, and toilet use. The care plan dated 5/5/20 documented Resident #16 had [DIAGNOSES REDACTED]. According to the care plan, the resident had lower body paralysis, numerous bladder issues, and used an indwelling catheter and a suprapubic catheter. The Care plan directed staff to provide catheter cares every shift and to change the catheter and collection system per order/policy. An order dated 3/06/20 directed staff to cleanse the suprapubic wound site with wound cleanser, apply zinc and stoma adhesive, and cover with a drain sponge twice a day. An order dated 9/7/19 directed staff to irrigate with acetic acid one time a day. The resident's record lacked orders regarding the size of catheter used and how often to change it. A review of the electronic record revealed a nurse's note dated 7/1/20 that showed staff changed the catheter due to leakage. The record from 2/1/20 to present had no other documentation of a catheter change. A review of the Treatment Administration Record (TAR) revealed the order to irrigate the catheter one time a day lacked initials 14 out of 30 opportunities in the month of June 2020. In the month of July 2020, the opportunity was missed 5 times. A review of the TAR revealed the order to cleanse the suprapubic wound site and cover with a drain sponge twice daily lacked initials 14 times in June 2020 and 6 times in July 2020. In an interview on 9/2/20 at 11:15 AM, Staff X, Certified Nursing Assistant (CNA) stated Resident #16's catheter leaked a lot. 4) According to an MDS dated [DATE], Resident #17 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS identified the resident scored 11/15 on the BIMS test which meant he experienced moderate cognitive deficits. According to the MDS, the resident required extensive assist of one staff for transfers, ambulation (walking), and dressing, and was totally dependent on one staff for toileting needs. The care plan for Resident #17 dated 7/1/20, documented the resident had an indwelling catheter due to a prostate disorder directed staff to change the catheter according to physician orders. A physician's orders [REDACTED]. A review of the TAR for the month of July 2020 revealed no documentation to show catheter had been changed on the 13th of the month or any other day in July. In an interview on 8/31/20 at 2:50 PM, the DON verified acknowledged the charts lacked documentation of catheter changes and therefore the nurses had no way of knowing if/when the catheters had been changed. She said the facility would be that nurses would change a catheter with clogging or sediment. The Catheter Care policy dated October 2016 documented the purpose of the policy: maintain consistent and adequate hygiene standards for residents with indwelling catheters. The procedure included hygiene guidelines only and did not include instruction or guidance for proper catheter placement, standards for timely catheter changes, or directives for following physician's orders [REDACTED].
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** Based on observations and interviews the facility failed to provide sufficient fluids to 4 of 6 residents reviewed (#3, 4, 6 and 8). The facility reported a census of 31 residents. Findings include: 1. According to the quarterly Minimum Data Set (MDS) assessment tool dated 6/15/20, Resident #3 had [DIAGNOSES REDACTED]. The MDS revealed the resident scored 13/15 on the Brief Interview for Mental Status test, which meant the resident displayed intact cognition. The MDS indicated she required extensive assist of 1 staff for transfers, dressing and toilet use and was independent with set up help for eating. The Care Plan dated 6/26/20 revealed Resident #3 was at risk for developing dehydration related to the use of diuretics for [MEDICAL CONDITION]. An interview with Resident #3 on 8/10/20 at 3:15 PM, revealed she had been moved out of isolation that day and did not have a water pitcher in her room or a glass to obtain water from the faucet. At 4:00 PM, the resident remained in her room without a water pitcher or a glass for water from the faucet. 2. According to the annual MDS dated [DATE], Resident #4 had [DIAGNOSES REDACTED]. The MDS revealed the resident scored 14/15 on the BIMS test which meant the resident displayed intact cognition. The MDS documented the resident as independent with transfers, dressing, and toilet use and required set-up help with supervision for eating. The Care Plan dated 7/1/20 revealed Resident #4 presented with positive lab results for Covid-19 on 7/24/20 and directed staff to encourage good fluid intake. An observation on 8/4/20 at 10:40 AM revealed Resident #4 on his bed with an over the bed table that contained an empty can of soda and Styrofoam containers. The room smelled strongly of urine and did not contain water pitchers or glasses. The resident declined an interview. In an additional observation on 8/4/20 at 3:25 PM., the room did not contain a water pitcher or any other means of hydration. The soda can and Styrofoam containers were gone. 3. According to the quarterly MDS dated [DATE], Resident #6 had [DIAGNOSES REDACTED]. The MDS revealed the resident scored 12/15 on the BIMS test which indicated the resident showed moderate cognitive impairment. The MDS coded the resident as independent with bed mobility, transfers, dressing, and toilet use and independent with eating with set-up help only. During an interview with Resident #6 on 8/4/20 at 10:55 AM he stated he just came out of isolation for testing positive for Covid-19. Observation revealed a water pitcher on his bed side table with warm water in it. He stated the staff do not fill them regularly and some days not at all. During a follow up observation on 8/4/20 at 3:30 PM, the resident still had no fresh water; the water pitcher in the room still contained warm water and the resident reported they did not pass ice water today. 4. According to the MDS dated [DATE], Resident #8 had [DIAGNOSES REDACTED]. The MDS revealed the resident scored 15/15 on the BIMS test which indicated the resident displayed intact cognitive abilities. The MDS documented she required extensive assist of 2 staff for transfers, dressing, and toilet use and had the ability to eat independently with with set-up help. The Care Plan dated 6/12/20 revealed Resident #8 presented with positive lab results for Covid-19 and directed staff to encourage good fluid intake. During an interview with Resident #8 on 8/4/20 at 10:50 AM, the resident had a half full water pitcher on her bed side table that contained warm water. Resident #8 reported staff fill them daily but not every shift. During an interview on 8/20/20 at 4:30 PM, the Director of Nursing stated that she has instructed the Certified Nursing Assistants to pass fresh ice water every shift and if it doesn't get done then she will do it.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on chart review and interview the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards for 6 of 19 residents reviewed (Residents #16, #17, #11, #19, #15, & #7). The facility reported a census of 31 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment tool dated 7/27/20, Resident #16 had been unable to participate in the Brief Interview for Mental Status (BIMS) assessment and had a severe cognitive deficit. According to the care plan dated 5/5/20, the resident had [DIAGNOSES REDACTED]. The care plan documented the resident had a potential for pain related to physical disability and a potential for impaired skin integrity with an indwelling catheter and a suprapubic catheter. The care plan directed staff to provide catheter cares every shift and change the catheter and collection system per order/policy. According to the physician's orders [REDACTED].#16 had treatment orders as follows: 1. An order dated 9/7/19 directed staff to irrigate the catheter with acetic acid solution one time daily. 2. An order dated 3/6/20 directed staff to cleanse the suprapubic wound site and cover with a drain sponge twice daily. 3. An order on 2/22/20 directed staff to apply an elbow protector to the right elbow while in bed twice a day. 4. An order on 9/6/19 directed staff to provide catheter care and clean the area with soap and water. On 9/14/20 at 9:00 AM, Staff Z in the business office verified that the Assistant Director of Nursing (ADON) did not work on 8/25 or 8/26/20. A review of a hard copy of the August 2020 treatment sheets revealed Staff J, ADON had initialed the above treatments as completed, but had signed for days she was not in work status: 8/25 - 8/26/20. 2) According to the MDS dated [DATE], Resident #17 had [DIAGNOSES REDACTED]. The care plan dated 7/1/20 documented Resident #17 had an indwelling catheter due to a prostate disorder and directed staff to change the catheter according to the physician's orders [REDACTED]. A review of a hard copy of the August 2020 treatment sheets revealed Staff J, ADON had initialed the above treatment as completed, but had signed for days she was not in work status: 8/25 - 8/26/20. 3) According to the MDS dated [DATE], Resident #11 had a Brief Interview for Mental Status score of 13/15 which meant the resident demonstrated intact cognition. The care plan dated 10/15/19, documented Resident #11 was at risk for bleeding due to anticoagulant therapy and the potential for impaired skin related to diabetes and incontinence. A physician's orders [REDACTED]. A review of a hard copy of the August 2020 treatment sheets revealed Staff J, ADON had initialed the above treatment as completed, but had signed for days she was not in work status: 8/25 - 8/26/20. 4) According to MDS dated [DATE], Resident #19 scored 4/15 on the BIMS test which meant the resident displayed severe cognitive impairment. The MDS documented the resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the electronic chart, the resident had the following physicians orders: Dated 8/10/20: [MEDICATION NAME] to left second toe two times a day Dated 8/10/20: [MEDICATION NAME] ointment to coccyx two

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F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) times a day for pressure. Dated 8/10/20: Triple antibiotic ointment to right lateral ankle A review of a hard copy of the August 2020 treatment sheets revealed Staff J, ADON had initialed the above treatment as completed, but had signed for days she was not in work status: 8/25 - 8/26/20. 5) According to the MDS dated [DATE], Resident #15 admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. The MDS showed the resident scored 15/15 on the BIMS, which meant he demonstrated intact cognition. Resident #15's care plan updated 5/5/20, documented the resident had altered respiratory status and also had a potential for altered nutritional status related to bolus tube feeding. The care plan documented the resident had actual skin impairment and directed staff to measure areas per facility guidelines with weekly skin assessment and to provide treatments to wounds according to the physician's orders [REDACTED]. The care plan directed staff to change the catheter per physician's orders [REDACTED]. According to the hospital report dated 8/23/20, the resident underwent [REDACTED]. On 8/25/20 at 6:30 PM, the Licensed [MEDICATION NAME] Nurse (LPN) that inserted the urinary catheter for Resident #15 documented a late entry in the electronic record and dated it for 8/19/20 at 10:06 AM. Staff O, LPN documented a CNA reported the resident's catheter had been leaking and he had little urinary output, so she put in a new catheter. She documented there was no resistance or other problems with the insertion. In an interview on 9/1/20 at 3:00 PM Staff S, CNA stated she had been on vacation from 8/10 - 8/14/20 and when she returned to work on 8/15/20 she learned Resident #15's catheter had been changed sometime while she was gone. She reported she noticed swelling of the scrotum on the 8/15/20 and reported it to a nurse at that time. She said the next time she worked was on 8/18/20 and she noticed the swelling had doubled from the weekend before. Staff S stated she had reported it to the nurse but did not know if there was any follow-up at that time. On 9/2/20 at 11:15 AM, Staff X, CNA verified she had worked 8/14 - 8/16/20 and 8/19 - 8/20/20. She said she provided catheter cares for Resident #15 on 8/14/20 and had noticed a decrease in urine output and leaking of the catheter. She stated on 8/15/20 she noticed swelling and reported it to Staff J, ADON but did not see what follow-up actions, if any, the nurse completed. In an interview on 9/1/20 at 1:00 PM, Staff P, Certified Med Aide (CMA) said that she had been working with Staff T, CNA on an overnight shift when she noticed Resident #15 had scrotal swelling and blood tinged urine, which she reported to a nurse. She added she could not remember which nurse she told or what the date it had been. A review of the timesheets revealed that Staff P and Staff T worked together on the overnight shifts on 8/12 - 8/14/20 and 8/17/20. According to the timesheets, these where the only overnight shifts the two staff worked together leading up to the resident's hospitalization on [DATE]. In an interview on 9/1/20 at 4:00 PM, Staff D, CNA said she was with Staff O, LPN when the catheter had been inserted for Resident #15. She said she hadn't noticed if the LPN was having any difficulty inserting the catheter but remembered there was a lot of urine output after it had been inserted. She also remembered she had worked the following day and at that time noticed swelling of the scrotum and then reported it to Staff J, ADON. She recalled this was a weekend shift and the RN directed her to keep an eye on it. Staff P said that she had a couple of days off but the next time that she worked, the scrotum had swollen to twice the size. A review of the timesheets for August revealed that Staff D and Staff O worked together on 8/10, 8/14, 8/16, and 8/19/20. Staff D worked with Staff J on 8/14 and 8/15/20. Throughout a conversation on 9/1/20, Staff P, CMA determined the catheter must have been inserted on 8/14/20 and she noticed the swelling and reported it on 8/15/20. She then figured she came back to work on 8/19/20 and noted the swelling was much worse. In an interview seeking clarification on 9/2/20 at 8:30 AM, Staff O, LPN was asked although she entered the late entry on 8/25/20 and dated it 8/19/20, could she have been mistaken about the date she inserted Resident #15's catheter? Staff O hesitated and then said she remembered Staff D, CNA had been with her and Staff O was pretty sure it was 8/19/20 instead. When asked what prompted her to add the late entry on 8/25/20, she reported the DON instructed her to put in a note. She said she was having trouble getting her charting completed and verified the standard would be to complete charting prior to leaving for the day. In a subsequent interview with Staff D, CNA on 9/3/20 at 10:47 AM, she reported she had been mistaken about the date the nurse changed the catheter: it was changed on 8/19.20. When reminded she said she noticed the swelling on the day after it was inserted and reported it to the nurse, according to the time sheets she did not work on 8/20/20. She responded she must have forgotten to clock in and out and she would get it cleared up with the business office. On 9/3/20 at 11:00 a.m., the DON said that Staff D had worked on 8/20/20 and she verified that by reviewing hard copy charting from 8/20/20 that included the initials of Staff D. In an interview on 9/16/20 at 2:00 p.m. with the facility's business office, Staff Z (business office personal) said Staff D had completed a missed punch form for 8/20/20 indicating she had worked that day but forgot to clock in or out. Again Staff Z was asked if she could get verification that showed she worked on 8/20/20, she reported she would talk to the DON about getting some verification. On 9/16/20 at 3:03 p.m., Staff D called to say the DON instructed her to call and explain that she had not actually worked on 8/20/20. Staff D reported when DON and she had looked at the resident charting, they were looking at 7/20/20 not 8/20/20. She said she had actually been at the emergency roiagnom on [DATE] because she got sick. On 9/16/20 at 6:00 PM, the DON said when she and Staff D were trying to determine if she had worked on 8/20/20 Staff D showed her a resident care document from 7/20/20 with her initials. The DON said she then recalled Staff D called in sick on 8/20/20 and did not work the shift. A review of the resident's record revealed numerous wound assessments in the resident's chart lacked measurements. In an interview on 8/25/20 at 2:20 PM, the DON said she documented the wound measurements on a flash drive so she could send those to the corporate office on a weekly basis. She reported she had a flash drive at home with the wound documentation. 6) According to the admission MDS dated [DATE], Resident #7 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS documented the resident scored 3/15 on his BIMS test, which meant he experienced severe cognitive impairment. The MDS dated [DATE], documented Resident #7 had a BIMS score of 9/15 which indicated a moderate cognitive deficit. The care plan dated 6/15/20 for Resident #7 indicated that he was at risk for falls, had severe cognitive impairment and chronic pain with arthritis in his hip. The care plan documented the resident had severe dementia that caused communication problems with difficulty understanding others and being understood. The care plan also stated that he had unreasonable, demanding behaviors and would often put himself on the floor. In an interview on 8/20/20 at 9:00 AM, the Director of Nursing (DON) was asked if the facility had any incident reports or elopements (when a resident leaves the facility without staff knowledge or permission) that involved Resident #7. The DON reported she had worked the weekend of 8/16/20 and the resident had gotten as far as the door on two occasions and opened it, he did not get outside and was always within line of site of staff. She added she did not have any incident reports for Resident #7. In an interview on 8/20/20 2:10 PM, Staff R CNA said that she had worked the overnight shifts 6 PM-6 AM for about a year. When asked about Resident #7 and his exit seeking behaviors she said she worked over the 8/16/20 weekend and he had opened the door and tried to exit several times. She reported the DON asked her to put an alarm on him. When asked about 5/22/20, she acknowledged she worked that night and found him in the fenced courtyard around the side of the building. She reported he had been naked from the waist down on all fours crawling on the sidewalk. She added that this must have been when he stubbed his toe that the nurses started treating several days later. Staff R said that he would often put himself on the floor and crawl up and down the hallways. In a follow up interview with Staff R CNA on 8/24/20 9:09 AM, this worker asked how long she thought Resident #7 may have been outside and she said she really couldn't say for sure. In an interview on 8/24/20 at 1:15 PM, Staff E, CNA remembered working a double shift on 5/22/20 and clocking out at 2:00 AM on 8/23/20. 22nd and having clocked out at 2 AM on May 23rd. She recalled that Resident #7 had gotten out the back door while she and Staff R were down the 100 hall. She said they did not hear the alarm until they got closer to the nurses station and found Resident #7 in the court yard, crawling. Staff E added they were told by the DON not to talk about the incident because she didn't want the administrator to know about it. In a follow up interview on 8/25/20 at 12:45 PM, Staff E CNA said that the DON had been at the front door waiting for someone to open it just after they had gotten Resident #7 back into his room. She reported when she went to open the door for her she told the DON what they had been doing. She said that the DON addressed them as a group (the ones that were working that night) and told them collectively that they would not talk about Resident #7 getting out because the administrator would be upset with her. In an interview on 8/20/20 4:00 PM Staff L RN stated she had no knowledge of any residents exiting the building on any of the overnight shifts that she worked. When asked if she remembered the night of 5/22/20, she said nothing came to mind. When asked specifically about Resident #7 exiting and being found in the court yard, she denied any knowledge of this and added that she is always on the move; if it did happen, the CNA's probably took care of it themselves. Staff L was then asked if she remembered working with Staff E as it had been unusual for Staff E to work an overnight shift. She then said she that she was remembered that night because they had two residents that they were dealing with; one with blood in his catheter and one with a spiked temperature. She said she had called the DON about these residents and she had come in to help. She then again denied having knowledge of Resident #7 leaving the building. When asked about the injury to the residents toe and she said that he often crawled on the floor up and down the hallways and he likely injured it that way. A review of the chart revealed an initial wound

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F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) assessment documented on 5/25/20 at 17:51 that identified a new skin tear to the left toe. The doctor and family were contacted at that time. In an interview on 8/24/20 at 1:00 PM regarding the night of 5/22/20, the DON reported she came into the facility in the middle of the night to assist with residents. She said she remembered she came to assist but could not remember what time of night it had been. She denied having any knowledge of Resident #7 getting out of the building that night. She went on to say she was shocked to have just learned about this incident after Staff R told her about the conversation that she had with this surveyor on 8/20/20. The DON stated that she did not remember if she had even seen or talked to either of the CNA's that were working that night because she and the RN were busy with the two residents down the 100 hall. She stated that she thought she was only at the facility for 45-60 minutes and reported that the RN did not say anything to her about Resident #7's exit into the courtyard. A review of the nursing documentation revealed an entry on 5/23/20 at 8:51 AM by Staff L that stated the resident had been restless, was on 30 minute checks because he crawled out of bed, pulled his adult incontinent brief off and crawled up and down the hallway. The note went on to say that they were unable to redirect him, he would not stay in bed so the CNA got him dressed and he sat in the TV room. In a follow up interview on 9/10/20 at 6:16 PM with Staff L she said that after a recent conversation with the DON, she reminded that she had actually gone outside and assisted the CNA's with Resident #7 when he exited on May 22nd. She said that once he was back inside she assessed him for any injuries and did not find any concerns. She added that until April, they would have two nurses on the overnight shift and since that time she's felt overwhelmed being the only nurse on that shift. She said that she called the DON that night because she hadn't ever irrigated a catheter before and the DON attended to that need. Staff L said she didn't know why she hadn't documented that the resident had gotten outside but she was probably in a hurry to clock out because she was getting pressured from the administrator to get her charting completed in a timely manner. She said she did not remember a conversation with the DON that night Resident #7. When asked about the injury to the residents toe she said she thought they had been treated the toe before this incident. In a follow up interview on 9/16/20 at 5:50 PM Staff R CMA, verified the RN came outside and helped them with Resident #7 after he exited. She said that Staff L helped them pick him up off the sidewalk and she and Staff E walked him to his room where the RN assessed him. She said that they cleaned him up and put him to bed and he stayed there the rest of the night. She said she didn't know where the DON had been at that time and she denied having any contact with the DON that night. She said that the elopement happened after the DON had left that night. A review of the electronic record revealed a note from the DON to nursing staff dated 5/21/20 that directed staff that charting must be completed every shift. She wrote it is never acceptable to leave the shift without charting and if nurses were not finished charting by the end of the shift, the nurses were expected to stays until completed. In an interview on 9/14/20 at 9:45 AM, the nurse consultant, administrator and DON acknowledged nursing documentation was an area of concern and they had already started to make changes. They stated they were surprised to discover that any of the nursing staff would initial treatments he or she had not actually completed and would follow up with the responsible parties.
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff and resident interviews, the facility failed to implement a comprehensive infection control program to mitigate the risk of spread of infection during a COVID-19 outbreak. The facility failed to complete infection control surveillance consistently on residents according to CMS and CDC guidelines and failed to isolate residents for a minimum of 10 days after the presence of COVID-19 symptoms first appeared. The facility also failed to provide care in accordance with accepted infection control standards and practices. Staff did not properly sanitize the sit to stand lift after use, wore incomplete or improper PPE, and failed to complete hand hygiene when indicated during resident personal care for 11 of 13 residents reviewed (#1, 2, 3, 4, 5, 6, 7, 9, 10, 11 and 13). During the COVID-19 pandemic, 30 residents and 17 staff tested positive for COVID-19 and 7 residents died due to complications of COVID-19. As a result of these findings, an Immediate Jeopardy (IJ) was identified to resident health and safety. The facility reported a census of 31 residents. Findings include: 1. According to the quarterly Minimum Data Set (MDS) assessment tool dated [DATE], Resident #1 had [DIAGNOSES REDACTED]. The MDS documented the resident scored ,[DATE] on the Brief Interview for Mental Status (BIMS) test which indicated the resident demonstrated moderate cognitive impairment. The MDS also documented he required extensive assist of 2 staff for transfers, walking in his room and toilet use, and extensive assist of 1 staff for dressing. The Care Plan dated [DATE] documented Resident #1 as at risk for contracting Covid-19 and also at risk of developing fatal complications. The Care Plan directed staff to follow CDC guidelines and recommendations for Covid-19. A care plan revision dated [DATE] included precautionary isolation through [DATE] and directed the licensed nurse to complete a comprehensive respiratory assessment and monitor and document vital signs every shift. Review of the clinical record revealed no vital signs or comprehensive assessments documented on [DATE]. The Progress Notes from ,[DATE]-[DATE] revealed Resident #1 placed in quarantine due to an outside doctor appointment on [DATE]. On [DATE], the Progress Notes documented the resident leaned to his left, displayed increased confusion and his skin became gray in color. He was sent to the hospital and admitted to rule out a [MEDICAL CONDITION] (stroke). The Emergency Department (ED) note dated [DATE] revealed the resident sent to ED for weakness. The physician documented the resident had a CT scan and he did not see any significant change since the last scan. The Hospital Infectious Disease Results dated [DATE] revealed Resident #1 tested positive for 2019 Novel Coronavirus. During an interview on [DATE] at 12:35 PM with a representative of the county public health department stated the facility had 7 reported deaths related to Covid-19 complications as any death within 28 days of a positive Covid-19 test counts as a Covid-19 death. The representative stated the facility's communication is getting better with the Iowa Department of Public Health (IDPH), but there is still room for improvement. The representative said they call and speak to the facility daily for testing and results, but the facility does not complete the workbook in its entirety as required. During an interview on [DATE] at 9:45 AM with a representative of the county public health department stated they have been trying to get the facility to follow IDPH guidance since [DATE] with regard to reporting requirements. The representative added it took 4 days to get a partial workbook of information completed, but the facility is not doing it daily as required. Spreadsheets provided by the facility titled COVID Testing and dated [DATE] revealed 30 residents had tested positive for COVID-19. One page titled COVID Positive Staff revealed 17 staff had tested positive for COVID-19. During an interview on [DATE] at 10:40 AM with Staff H, she stated the transition hall (precautionary isolation) had never been shut or sealed. The plastic put in place and pulled back signified the facility used it as a transition hall for new admissions or residents with unknown infection status. Staff H reported staff wear goggles and masks in the transition hall, but not gowns or gloves. She added that in March or April she was educated on the new requirements for cleaning, but there are days she thinks they don't have enough housekeepers to keep up. During an interview on [DATE] at 11:00 AM, the Director of Nursing (DON), reported nurses work 12 hour shifts and are expected to complete a temperature and Covid-19 Risk Assessment every shift for every resident. During an interview on [DATE] at 12:35 PM with the Assistant Director of Nursing (ADON), she stated she has worked at the facility for 3 years. She reported the facility never sealed or separated the transition hall from the rest of the facility, although they kept the residents' doors shut. She also reported staff wore masks and goggles but did not consistently wear gowns in resident rooms on the transition hall. During an interview on [DATE] at 12:50 PM with the DON she stated all new admissions, readmissions, or residents that have been out for appointments go to the transition hall. She added they do not keep the hall closed or sealed and the staff are to wear their masks and goggles but have never been required to wear gowns on the hall. 2. According to the quarterly MDS dated [DATE], Resident #2 had [DIAGNOSES REDACTED]. The MDS documented the resident scored ,[DATE] on the BIMS indication he displayed intact cognition. The MDS revealed he was totally dependent on 2 staff for transfers and totally dependent on 1 staff for dressing and toilet use. The Care Plan dated [DATE] revealed Resident #2 was at risk for contracting Covid-19 and also at risk for fatal complications. The Care Plan directed staff to follow CDC guidelines and recommendations for Covid-19. Review of Resident #2's clinical record revealed no documentation of vitals and a comprehensive assessment on ,[DATE], ,[DATE], ,[DATE] and [DATE]. 3. According to the quarterly MDS dated [DATE], Resident #3 had [DIAGNOSES REDACTED]. The MDS documented she scored ,[DATE] on the BIMS which indicated the resident demonstrated intact cognition. The MDS indicated she required extensive assist of 1 staff for transfers, dressing and toileting; and was independent with set up help for eating. The Care Plan dated [DATE] revealed Resident #3 was at risk for contracting Covid-19 and also at risk for fatal complications. The Care Plan directed staff to follow CDC guidelines and recommendations for Covid-19. Review of Resident #3's clinical record revealed it lacked documentation of vital signs and a comprehensive assessment on ,[DATE], ,[DATE], ,[DATE] and [DATE]. Further record review revealed only one set of vital signs with a corresponding comprehensive assessment on one shift on ,[DATE], ,[DATE], ,[DATE], ,[DATE] and [DATE].

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	165230	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 9) Observation on [DATE] at 1:00 PM revealed Resident #3 in a hospital gown in the shower room with Staff E and Staff I present for cares and shower during transfer from the Covid Isolation Hall (no longer had a positive COVID-19 test) back to her previous room. Both aides washed their hands and donned clean gloves. Staff E moved the lift while Staff I provided cares. Staff raised the resident's bare feet were raised and placed them on the visibly dirty lift platform. The front edge of the platform contained dirt and loose, varied types of small debris. Staff applied the sling around the resident's waist and Staff E raised the lift which assisted the resident to stand while connected to the lift. Staff I removed a urine soaked brief but did not remove her soiled gloves. She then unattached the sling from the lift with her dirty gloves and removed the sling from around the resident. Staff I then removed her gloves and used hand sanitizer. After the resident's shower, both aides present used hand sanitizer and applied clean gloves. Staff E moved the lift and helped Staff I attach the sling to the resident. Staff E raised the lift while Staff I dried the resident's backside. She then removed her gloves, sanitized and donned new gloves before applying a clean brief and pulling up the resident's clothes. Staff applied a mask to move Resident #3 to the hall and through the hallway to her room. After delivering the resident to her room, staff moved the lift to the hall without sanitizing it. During a tour of the halls of the facility on [DATE] at 1:45 PM identified sit to stand lifts numbered 3, 4 and 6. All were visibly dirty and contained dirt and small particles and debris on the foot platform, on the top of the leg cushion, and on the handle bars where the resident had to grip to stand when staff raises the machine. During an interview with the Director of Nursing on [DATE] at 2:10 PM she stated the facility has 5 sit to stand lifts to share between all the residents and staff are to sanitize the lifts between each resident and each hall. 4. According to the annual MDS dated [DATE], Resident #4 had [DIAGNOSES REDACTED]. The MDS documented he scored ,[DATE] on the BIMS which indicated he showed an intact cognitive status. The MDS indicated he was independent with transfers, dressing and toilet use and required set up help with supervision for eating and minimal assist of 1 staff for his bath. The Care Plan dated [DATE] revealed Resident #4 presented with positive lab results drawn on for Covid-19 on [DATE]. It directed staff to follow CDC guidelines and recommendations for Covid-19, monitor vital signs every shift, and initiate and maintain droplet isolation precautions. Review of Resident #4's clinical record revealed it lacked documentation of vital signs and a comprehensive assessment on ,[DATE], ,[DATE], ,[DATE] and [DATE], and only on one shift on ,[DATE], ,[DATE], ,[DATE] and [DATE]. The Director of Nursing provided a facility Resident Isolation Spreadsheet on [DATE] which listed all the residents that tested positive for Covid-19 with their start and stop dates for isolation. It listed Resident #4's test date as [DATE] and start date for isolation [DATE]. The Progress Notes revealed Resident #4 was in isolation on [DATE] and then moved from the isolation hall on [DATE] (9 days). The Progress Notes dated ,[DATE]-[DATE] documented Resident #4 as lethargic. The Temperature Summary for Resident #4 revealed he had a fever of 99.9 on [DATE]. The facility policy Discontinuation of Transmission Based Precautions Covid-19 revised [DATE] instructed staff to discontinue transmission based precautions for individuals with confirmed Covid-19 using a symptom-based, test-based or time-based strategy. Definition: a. Symptom-based strategy: afebrile for 24 hours without the use of fever reducing medications AND improvement in respiratory symptoms AND at least 10 days since symptom onset. b. Test-based strategy: individuals with critical illness and are severely immunocompromised AND at least 20 days from the date of the positive Covid-19 test AND negative results form of an FDA authorized Covid-19 test (2) consecutive respiratory specimens collected more than 24 hours apart. c. Time-based strategy: asymptomatic AND at least 10 days from the date of the positive Covid-19 test. 5. The annual MDS dated [DATE] revealed Resident #5 had [DIAGNOSES REDACTED]. The MDS documented the resident experienced severe cognitive impairment and was totally dependent on staff for bed mobility, transfers, toilet use, and dressing. The Care Plan dated [DATE] revealed the resident [MEDICAL CONDITION] at his gastrostomy tube site and is at risk for contracting Covid-19 with fatal complications. During an observation of cares on [DATE] at 1:00 PM, Staff A and Staff B, Certified Nursing Assistants (CNAs) wearing mask and goggles, don gown and gloves to enter Resident #5's room. The resident's room door had a sign posted on the outside of the door that directed the resident was on droplet precautions. The aides stated the resident is not positive for Covid-19, but was on droplet precautions due to his ventilator. The resident's room contained small, random debris on the floor on both sides of the bed on the floor. The nursing assistants rolled the resident to his left side and Staff B removed a urine soaked brief and provided perineal care with wipes that sat at the foot of the bed. Staff B completed perineal care on the right side and then adjusted her goggles on her face with the same gloves she had been wearing during cares and then assisted Staff A to roll the resident on his right side. Staff A rolled up the dirty brief and discarded it in the trash next to her and then used wipes to provide care on the resident's left side. She then put a clean brief under him, but did not remove her dirty gloves. They rolled the resident to his back and Staff A provided perineal care for the resident's front, then they pulled up the brief between his legs and then rolled him slightly to his left side to finish adjusting the brief. Neither aide had removed their dirty gloves or completed any hand hygiene since entering in the room. Staff B adjusted the bed with the bed remote in her dirty gloved hand and Staff A adjusted the gastrostomy feeding tube and then the vent tube. Staff B then retrieved paper towels and a graduate to empty the Resident #5's gastric catheter. She did not change her gloves or do complete hand hygiene between perineal care and gastric catheter care. After all cares were completed, both CNAs removed the gloves they donned prior to entering the room and then washed their hands before leaving the room. During an interview with the Respiratory therapist that walked by as everyone exited the room, she agreed the floor was dirty and stated she believed it was food because the resident's roommate had been known to throw food. She stated she would have it cleaned immediately. 6. According to the quarterly MDS dated [DATE] for Resident #6 scored him at ,[DATE] for the Brief Interview of Mental Status indicating moderately cognitively impaired. The MDS coded him as independent with bed mobility, transfers, dressing and toileting and independent with eating with set up help only. It listed [DIAGNOSES REDACTED]. The Care Plan dated [DATE] for Resident #6 revealed he was at risk for contracting Covid-19 and was at risk for fatal complications. The Care Plan directed staff to follow CDC guidelines and recommendations for Covid-19. The CDC website specific for Nursing Homes, updated [DATE] and still current as of [DATE], titled Preparing for COVID-19 in Nursing Homes, https://www.cdc.gov/Coronavirus/2019-ncov/hcp/long-term-care.html included the following guidelines about facilities screening residents daily for signs/symptoms of COVID-19: Evaluate and Manage Residents with Symptoms of COVID-19. Ask residents to report if they feel feverish or have symptoms consistent with COVID-19. Actively monitor all residents upon admission and at least daily for fever (T=100.0oF) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions as described below. Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0oF might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19. The CDC link for symptoms consistent with COVID-19, updated [DATE], included the following recommendations on watching for symptoms: People with COVID-19 have had a wide range of symptoms reported - ranging from mild symptoms to severe illness. Symptoms may appear ,[DATE] days after exposure to [MEDICAL CONDITION]. People with these symptoms may have COVID-19: Fever or chills Cough Shortness of breath or difficulty breathing Fatigue Muscle or body aches Headache New loss of taste or smell Sore throat Congestion or runny nose Nausea or vomiting Diarrhea This list does not include all possible symptoms. CDC would continue to update this list as we learn more about COVID-19. Record review of the clinical record revealed Resident #6 lacked documentation of vitals and a comprehensive assessment on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE] and [DATE]. The facility Resident Isolation Spreadsheet revealed Resident #6 was started on isolation [DATE] and stopped isolation on [DATE] which totaled 9 days in isolation. The Progress Notes dated [DATE] for Resident #6 revealed he had rhonchi in his upper lobes and was having loose stools. Review of the Progress Notes revealed he continued to have abnormal lung sounds through [DATE] when he was taken out of isolation. During an interview with Resident #6 on [DATE] at 10:55 AM he stated he just came off isolation for testing positive for Covid-19. He stated he is still having nausea but is negative as far as he knows. The CDC website specific for Nursing Homes updated [DATE], titled Preparing for COVID-19 in Nursing Homes, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html included the following guidelines about keeping a new or readmitted resident in quarantine for 14 days: Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown. Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 10) without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected. The facility removed Resident #6 from isolation on [DATE] while he still exhibited the respiratory symptom of abnormal lung sounds. 7. The quarterly MDS dated [DATE] for Resident #7 listed [DIAGNOSES REDACTED]. The MDS documented the resident scored ,[DATE] on the BIMS test which meant the resident displayed moderate cognitive impairment. The MDS documented the resident as totally dependent on 1 staff for transfers, dressing and toilet use. The Care Plan dated [DATE] documented Resident #7 as at risk for contracting Covid-19 and also at risk for fatal complications. The Care Plan directed staff to follow CDC guidelines and recommendations for Covid-19. Record review of the clinical record lacked documentation of vitals and a comprehensive assessment provided for Resident #7 on [DATE] and ,[DATE]-[DATE]. The Resident Isolation Spreadsheet revealed Resident #7 began isolation on [DATE] and left isolation on [DATE], a total of 9 days in isolation. A Progress Note dated [DATE] revealed the resident had an oxygen saturation of 84 percent, which was the first documented abnormal symptom, however the clinical record on ,[DATE]-[DATE] lacked any documentation of a lung assessment. 8. According to the quarterly MDS dated [DATE], Resident #9 had [DIAGNOSES REDACTED]. The MDS documented the resident scored ,[DATE] on the BIMS test which indicated she demonstrated moderately impaired cognitive abilities. The MDS showed the resident required extensive assist of 1 staff for transfers, dressing, toilet use, and bathing. The Care Plan dated [DATE] documented Resident #9 as at risk for contracting Covid-19 and also at risk for fatal complications. The Care Plan directed staff to follow CDC guidelines and recommendations for Covid-19, monitor vital signs every shift, and report any status changes to the physician. Resident #9's clinical record lacked documentation staff completed temperature and lung assessments every shift on ,[DATE] and [DATE]. Record review of the Progress Notes revealed: a. On ,[DATE] and [DATE] the resident's respirations were labored with lung sounds diminished. b. On [DATE] the resident had shortness of breath and diminished lung sounds with an oxygen saturation of 79% c. On [DATE] the resident's oxygen saturation went from 43% to 70% percent by adding 10 liters of oxygen. d. On [DATE] the resident had clammy and pale skin and exhibited intermittent confusion with episodes of combative behavior and oxygen saturations of ,[DATE]% on 10 liters of oxygen. The nurse notified the physician and sent the resident to the emergency room . 9. According to the annual MDS dated [DATE], Resident #10 had [DIAGNOSES REDACTED]. The MDS documented the resident required extensive assist of 1 staff for transfers, dressing and toilet use. Observation on [DATE] at 11:15 AM revealed Staff D and Staff B entered Resident # 10's room, washed their hands, and donned gloves. Staff D moved a sit to stand lift in front of the resident and explained cares to her. The resident lifted her sock covered feet onto the platform that was covered in dirt and debris and grabbed the hand grip bars as the CNAs put the sling around her waist and attached the strap around her lower legs. Staff D raised the lift as Staff B removed a urine soaked pad from under Resident #10. Staff B then removed her gloves, sanitized her hands and donned new gloves. Staff D handed Staff B the wipes as Staff B cleansed the resident's back side with three wipes used to wipe the right back, left buttock and rectal area. Staff B removed her gloves, sanitized her hands and donned new gloves. She then placed a new clean brief in the recliner and both CNAs moved the lift to the recliner and lowered the resident into it. Staff did not cleanse the resident's front, including the vaginal area. Towels hung under the front side of the resident's gown, and Staff D reported the resident had towels in her skin folds due to redness and excoriation. Both CNAs removed their gloves, sanitized their hands and donned clean gloves. Staff B picked up the room while Staff D sanitized the sit to stand lift. She used bleach wipes and sanitized the handles the CNAs had used, the control panel, and the top rail above the resident hand grips. Staff D did not sanitize the bars the resident grasped during the transfer or the platform under her feet. She then moved the lift to the hallway. Observation on [DATE] at 9:55 AM revealed Staff D, CNA exited a resident's room wearing her mask properly, but wearing her goggles on top of her head. She used hand sanitizer and then proceeded down the hall. The facility was notified of the IJ on [DATE]. The facility abated the Immediate Jeopardy on [DATE] by taking the following actions: a. The Director of Nursing/Designee completed an audit to ensure COVID-19 assessments were completed on each resident on [DATE] at 4:00 PM. Each resident had a COVID-19 assessment completed [DATE] and will have at least one assessment completed daily moving forward. b. The facility has educated all staff regarding completion of daily respiratory assessments for signs/symptoms of COVID-19 for all residents; the discontinuation of transmission-based precautions, proper use of PPE, and instructions on what PPE should be used in what parts of the facility; and cleansing of the lifts between resident uses. Facility policy H9 Novel Coronavirus COVID-19 dated [DATE] and facility policy H5 Discontinuation Transmission Based Precautions COVID-19 dated [DATE] were reviewed with all staff with completion date [DATE] by 6:15 PM. c. Audits will be completed by the Director of Nursing/Designee periodically on the day and night shifts. d. Audits will be taken to the QAPI monthly meetings for review. 11) According to the Minimum Data Set (MDS) dated [DATE]th 2020 Resident #11 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating intact cognitive response. According to the MDS she required extensive assistant with the help of one person for transfers, dressing, bathing and toileting. According to the physician's orders [REDACTED].#11 had [DIAGNOSES REDACTED]. The POS indicated an order for [REDACTED]. In an observation on [DATE] at 1:10 PM Staff W CNA was assisting Resident #11 with her meal. The resident was in bed with nasal cannula and oxygen set on 3 liters. As Staff W went over the bedside she stood on the oxygen tubing that was laying on the floor. Upon closer inspection it was discovered that the tubing lacked information indicating when it had been last changed. In an interview on [DATE] at 10:30 AM Staff Y, respiratory therapist, said that she had just gotten back to work on ,[DATE] after having being out for a couple of weeks. She had with her the sheet she uses to document when oxygen tubing is changed. She said that when she changes it, she will document the date on a piece of tape. The resident was started on oxygen on the 13th so that's when the tubing would have been put on. DON stated that she would reeducate nursing staff on weekly changes of tubing and dating when it's started. Upon further review of the chart revealed that the resident did not have a physician's orders [REDACTED]. 12) According to the MDS dated [DATE], Resident #13 had a BIMS score of ,[DATE] which meant he displayed a moderate cognitive deficit. The MDS documented the resident as independent with transfers, ambulation, dressing and toilet use. The care plan last updated [DATE] documented a potential for acute and chronic pain related to [DIAGNOSES REDACTED] and also documented the resident as at risk for falls and a self-care performance deficit. The care plan included [DIAGNOSES REDACTED]. In an observation on [DATE] 10:50 AM, Staff E CNA offered Resident #13 a shower. The shower room had a whirlpool tub that Staff E verified had not worked for at least 5 months and also verified the residents used this shower room only. A shower chair was in the corner next to a hand-held shower wand that hung on the wall and a very soiled shower curtain hung next to the door and separated the shower area for privacy purposes. Resident #13 was independent with his shower, he removed his clothes, sat in the shower chair and used the hand-held shower wand to wash himself. Several times he propelled himself closer to the CNA and pulled back the curtain. When the resident was clothed and left the room, Staff E sanitized the shower chair and folding chair with sanitizer, but failed to spray the curtain, shower wand, floor, or wall. Staff E immediately rinsed and wiped the sanitizer off of the chair. When asked about the required contact time of the sanitizing agent, she was unable to say for sure. In an interview on [DATE] at 10:00 the Director of Nursing (DON) went into the shower room and observed the dirty shower curtain, floor, walls, and the dust filled window vent. When asked about her expectations for cleaning of the area between uses she said that it would be expected to clean the shower chair and the handles and hand held shower wand. The DON reported she would educate staff regarding the contact time for the sanitizer and would make sure the to have the curtain changed and surfaces thoroughly cleaned.