STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265556	A. BUILDING _____ B. WING _____	08/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKDALE CARE CENTER	2702 DEBBIE LANE POPLAR BLUFF, MO 63901

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm** - Minimal harm or potential for 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 give one resident (Resident #1) out of three sampled residents with a pressure ulcer, the necessary treatment and services to promote healing and prevent infection. The facility census was 67. Record review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 3/10/20, showed: - admitted on [DATE] with a stage 2 wound on the coccyx (Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister) and moisture associated skin damage. - Medically complex condition, 13 diagnoses; including recurrent small bowel obstruction, chronic diarrhea, arthritis, chronic pain, chronic [MEDICAL CONDITION], peripheral vascular disorder, and high blood pressure. - Could make needs known; - Pressure reduction mattress, turn and reposition program. - On physical and occupational therapy. - No behaviors, no rejection of care. - Limited assist of one person with all Activities of Daily Living (ADL), except for bathing which required extensive assist of two; Ambulated with walker assist of one staff. - Weighed 94 pounds; - [MEDICATION NAME] for urinary diversion and occasional bowel incontinence. Review of the physician's orders [REDACTED]. Change dressing daily and PRN(as needed) until healed. Once an evening 3:00 PM to 5:00 PM. Further review showed no orders for supplements or for additional dietary needs. Review of the Registered Dietician's note, dated 3/5/20, showed Resident #1: - Ate 26 - 50 % each meal; - Required 1050 cc fluid intake for history of urinary tract infection and dehydration; - Required 50 grams of protein for wound healing, low [MEDICATION NAME], recent trauma, and high level nutritional support needed; - Needed 1260 total calories and high level nutritional support. - Add House Supplement three times a day due to underweight and skin breakdown. Record review showed: - No documentation of the resident's supplement intake or meal consumption; - No documentation of the resident's weight after the initial taken upon admission. Review of nurses' notes, dated 3/3/20 to 3/24/20, showed: - On 3/3/20, staff noted Resident #1 had a reddened coccyx and peri area, with a stage 2 pressure ulcer on the coccyx. New order noted for treatment to the coccyx; - Entries for the resident showed he/she ambulated in the hall with a walker and ate meals in the dining room until the lockdown related to the pandemic; - Multiple daily notes documented the resident turned and repositioned him/herself; - On 3/21/20, resident sent to local hospital. Right lower extremity found to be red and hot to touch. Elevated temperature of 103.6 degrees; - On 3/24/20, Registered Nurse (RN) B wrote a late entry for 3/17/20 (7 days prior) and noted a stage 2 pressure ulcer to the coccyx during a dressing change; - No other documentation on the stage 2 pressure ulcer found in the nurse's notes. Review of the Treatment Administration Sheet, dated March 1 to March 31, 2020 showed second shift staff provided the treatment to the coccyx as ordered. Review of shower sheets (forms filled out by nurse aides during bathing to indicate skin issues on residents) showed: - On 3/7/20, no skin abnormalities, signed by the aide and the nurse; - On 3/11/20, the coccyx area circled, abnormal color and decubitus noted, bed bath given, signed by the aide and the nurse; - On 3/14/20, no skin abnormalities, bed bath given, signed by the aide and the nurse; - On 3/18/20, the coccyx area circled, abnormal color and decubitus, bed bath given, signed by aide and nurse; - On 3/21/20, no skin abnormalities, resident refused bath, signed by aide and nurse. Review of the wound sheets for the month of March, 2020 showed Resident #1 did not receive wound care services. Review of the resident's care plan, initiated 3/5/20, showed the following: - Conduct a systematic skin assessment weekly for four weeks; - Report any signs of skin breakdown. - Turn and reposition every two hours. No weekly skin assessment sheets were found for Resident #1. No wound measurements were found for Resident #1. A second care plan, dated 3/18/20, showed the following: - Dietary changes, between meal snacks, house supplement three times a day with meals, dated 3/10/20; - Observe and report signs of [MEDICAL CONDITION]; - Report any signs of further skin breakdown. Review of the hospital record showed showed the following: - An admission date of [DATE], for management [MEDICAL CONDITION] related to right leg [MEDICAL CONDITION] and bilateral pneumonia; - A picture of the coccyx taken on 3/21/20 by the hospital, showing a large wound with an unspecified cover of the wound base; - On 3/23/20, Resident #1 seen in consultation for a nonstageable ulcer to the sacrum (It was determined to be a sacral wound, not a coccygeal wound by the consulting physician,) with majority slough, some maroon discolored area, moderate drainage, peri-ulcer [DIAGNOSES REDACTED]; - Bedside debridement (the removal of devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process. Debridement methods may include a range of treatments such as the use of enzymatic dressings to surgical debridement in order to remove tissue or matter from a wound to promote healing) completed on 3/24/20, 3/30/20 and 4/3/20. Was found to have a large stage 4 sacral ulcer (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough) with exposed bone. On 4/6/20, the wound was listed as 5 cm. - On 4/10/20 seen by specialist due to concerns of osteo[DIAGNOSES REDACTED] (bone infection). Determined to need operative intervention with a thorough debridement and biopsy of the sacrum and coccyx. Resident #1 started on three broad spectrum antibiotics for acute osteo[DIAGNOSES REDACTED]. In an interview on 7/7/20 at 10:35 AM., the Assistant Director of Nursing (ADON) said a charge nurse is to look at every resident at shower time and bed baths The nurse aides fill out the the shower sheet noting any abnormal skin and then turn the form in to the Charge Nurse for review. After review by the Charge Nurse, the forms go to the ADON. Currently, all wounds are seen by the wound service. In a later interview at 11:20 AM, the ADON said Resident #1 did not qualify for the wound service because the wound was a stage 2 and was instead seen by the dietician. The ADON said he/she seen the wound on 3/9/20, and it was a stage 2. In an interview on 7/29/20 at 3:36 PM, the Licensed Practical Nurse (who works for the Resident's physician) said the records did not show that the facility called the physician with a report of a worsening wound. If they faxed a report, the physician would have addressed it and the order added to his/her chart. In an interview on 7/29/20 at 3:51 P.M., RN B said he/she last seen Resident #1's wound on 3/17/20. At that time, it was a stage 2. On 3/24/20 (seven days after the observation), the Director of Nursing (DON) asked RN B what the wound looked like the last time he/she seen it and to document that as a late entry. In an interview on 7/7/20 at 11:30 A.M., the DON said there is no follow up documentation in the nurses' notes for Resident #1's wounds. The DON had been informed the wound was a stage 4 at the hospital. Review of the facility's Wound Care Program showed: - Staff are to expect a clean ulcer with adequate interventions and blood supply to show evidence of healing within two weeks. - Failure to do so should prompt a reevaluation of the plan of care, evaluation of adherence to the plan, and a possible modification of the plan. Complaint #MO 6
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to properly prevent or contain the possible spread of COVID-19 by failing to appropriately utilize personal protective equipment (PPE) and perform appropriate hand hygiene. Additionally, facility staff failed to properly sanitize the glucometer between resident use according to the manufacturer's instructions. The facility census was 68. Review of the Centers for Disease Control and Prevention (CDC) recommendation dated 5/21/20, showed in order to prevent the spread of COVID-19, facility staff are to ensure all

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

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) healthcare personnel (HCP) wear a facemask or cloth face covering for source control while in the facility. Additional review of the CDC recommendation titled How to Wear Face Coverings Correctly dated 5/22/20, showed staff are to place it over their nose and mouth and secure it under their chin. The CDC recommends 6-foot social distancing among people. Record review of the facility's policy, COVID-19 Policy and Procedure, dated 6/22/2020, showed no policy regarding use of facemask with no suspected or confirmed cases of COVID 19. Residents will be reminded to practice social distancing and perform frequent hand hygiene. If equipment must be used for more than one resident, it will be cleaned and disinfected before use on another resident, according to manufacturer's recommendations using EPA-registered disinfectants against COVID-19. If there are no available EPA-registered products that have an approval emerging [MEDICAL CONDITION] pathogen claim for COVID-19, products with label claims against human coronaviruses should be used according to label instructions. 1. On 7/16/2020 at 9:10 A.M., observations showed: - Nurse Aide (NA) D stood at the front entry way of the facility with a facemask around his/her neck. NA D instructed surveyors to self-screen before entering through the fire doors into the skilled nursing residential area. NA D then re-entered the fire doors leading to the residential area of the facility with the facemask around his/her neck. During an interview on 7/16/2020 at 9:40 A.M., Certified Nurse Aide (CNA) G said all staff are required to wear a facemask at all times while in the facility. On 7/16/2020, observations showed: - At 9:45 A.M., Resident 4#'s room had a sign on the outside of the door which directed staff to use precautions with PPE including mask, gown, and gloves. All of the PPE listed available outside the doorway. NA D entered Resident #4's room without donning PPE. NA D wore his/her mask below his/her face, walked within six feet of the resident who sat in the room without a facemask and turned off the call light. NA D left the room and returned to the hallway without washing his/her hands or using hand sanitizer; - At 9:47 A.M., NA D approached Resident #4's room, donned a gown, gloves, and with facemask below his/her chin entered the room. NA D walked around the room touching the resident's wheelchair, blinds, bedside table, touched the resident's hands then left the room without washing or sanitizing his/her hands. During an interview on 7/16/2020 at 9:50 A.M., NA D said he/she was not sure what the facility policy was regarding the use of PPE; although, he/she probably should have put on the PPE prior to entering the resident room. 2. On 7/16/2020 at 9:55 A.M., observations showed: - Licensed Practical Nurse (LPN) E, and Registered Nurse (RN) F sitting at the nurse's station reviewing paperwork. LPN E had his/her facemask around his/her neck not covering his/her face. During an interview on 7/16/2020 at 10:00 A.M., LPN E said the former Administration informed him/her facemasks were not required behind the nurses station due to residents not being allowed there. LPN E said he/she is unsure what the current facility policy is regarding the use of facemask. During an interview on 7/16/2020 at 10:05 A.M., RN F said the former Administration informed him/her facemasks were not required behind the nurses station due to residents not being allowed there; although, he/she would still wear his/her mask all day while working at the facility regardless of the facility policy. During an interview on 7/16/2020 at 10:10 A.M., the Director of Nursing (DON) and the Regional Facility Nurse (RFN) said they expected all staff to wear masks covering their faces while in the facility at all times. 3. Record review of the glucometer's manufactures guidelines regarding the cleaning and disinfecting of the glucometer machine showed: - To disinfect the meter, clean the meter with one of the validated disinfecting wipes; - Wipe all external areas of the meter including the front and back surfaces until visibly clean; - Allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipes direction for use; - Wipe meter dry or allow to air dry; - Wash hands thoroughly with soap and water and dry thoroughly. Observations on 7/16/2020 at 10:50 A.M., showed: - RN F performed a glucometer reading on Resident #5, exited the room and used hand sanitizer to clean the glucometer; - RN F then entered Resident #6's room with the same glucometer cleaned with hand sanitizer and performed a glucometer reading, exited the room and cleaned the glucometer again with hand sanitizer. Observation on 7/16/2020 at 10:55 A.M., showed no disinfecting wipes available for use on the medication cart. During an interview on 7/16/2020 at 11:00 A.M., RN F said he/she uses the hand sanitizer to clean the glucometer between each use on the residents; although, if the resident was on isolation, he/she would use a purple top disinfecting wipe. During an interview on 7/16/2020 at 11:10 A.M., the DON said she expected nursing staff to clean the glucometer with disinfecting wipes between each resident use according to the manufactures guidelines.