

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

PRINTED: 08/17/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/10/2021
NAME OF PROVIDER OR SUPPLIER  OAKNOLL RETIREMENT RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 1 OAKNOLL CT IOWA CITY, IA 52240		
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F 000	INITIAL COMMENTS  Correction Date: <u>8/27/2021</u>  The following deficiencies relate to the Recertification Survey and investigation of Complaint #98852 and a Facility Self-Reported Incident #99045 conducted on 8/2/21 to 8/10/21. Complaint #98852-C was partially substantiated and Incident #99045 was substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C). The facility reported a resident census of 52.	F 000			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview the facility failed to ensure identified	F 610			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kim Bergen-Jackson</i>	TITLE Kim Bergen-Jackson, Administrator	(X8) DATE 08/17/2021
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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 610	<p>Continued From page 1</p> <p>areas of skin impairment with unknown etiology were thoroughly investigated for 1 of 1 resident reviewed for injuries of unknown origin (Resident #23). The facility reported a census of 52 residents.</p> <p>Findings Include:</p> <p>The Minimum Data Set (MDS) Assessment dated 5/22/21 revealed Resident #23 rarely to never understood, had severely impaired cognition, and had a short term and long term memory problem.</p> <p>The Progress Note dated 5/11/2021 at 8:45 AM documented, Skin/Wound Note: Certified Nursing Assistant (CNA) alerted this Nurse of skin tear to Left forearm (LFA); unknown etiology. Cleansed 4.5 linear skin tear to LFA with normal saline (NS) and covered with non-stick telfa et roll gauze." An Incident Report form was not received which addressed this injury.</p> <p>The Incident Report dated 6/20/21 at 12:15 AM revealed, Assisted resident into bed about 30 minutes later. At approximately 3:00 AM, the CNA notified nurse that the resident was bleeding from her shin. Resident still in bed but had her legs hanging off the side of the bed. Upon assessment the resident had an open wound on her right shin about 4 centimeters (cm) in diameter. Skin over the wound had completely come off, when looking around noticed the flap of skin sitting on resident's foot. It is unclear how the resident injured herself as she was still in bed and had not fallen out of bed. The corresponding Incident Note dated 6/20/21 at 6:42 AM did not provide additional information about Resident #23's right shin wound.</p>	F 610		

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F 610	<p>Continued From page 2</p> <p>The Progress Note dated 7/18/2021 at 3:03 PM documented, Skin/Wound Note: CNA alerted this Nurse of blood on the bed sheet with source noted to be an open triangular 1.5 cm x 3.0 cm skin tear to the upper right posterior thigh region; etiology unknown. Family notified, Medical Doctor faxed. This Progress Note had been authored by Staff B, Licensed Practical Nurse (LPN). An Incident Report form was not received from the facility which addressed this injury.</p> <p>Observation on 8/02/21 at 10:25 AM revealed Resident #23 was seated in a high back wheelchair. The resident stated, "Did I have my dinner?"</p> <p>In an interview on 8/04/21 at 11:16 AM, Staff B, LPN was queried as to the identity of the CNA who had alerted them of the resident's injury on 7/18/21. Staff B was not able to recall. Staff B explained if it was not determined how the event occurred then the etiology would be unknown. Staff B further explained they would notify the physician. When queried as to when they would notify the facility Administrator of an injury of unknown origin, Staff B explained the process would occur internally and would be completed in the computer somewhere.</p> <p>In an interview on 8/05/21 at 9:37 AM, Staff A, Registered Nurse (RN), was queried as to the process followed when an injury of unknown origin had been discovered. Staff A explained they would first assess the wound, determine if it was bleeding or not, and would assess the current condition. Staff A explained they would radio for help, tell others to bring supplies, obtain vitals, and would ask the resident if they were having any pain. Then after the resident was</p>	F 610			

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F 610	<p>Continued From page 3</p> <p>situated, they would get the resident back to their room, would complete a full skin assessment, would determine if there was any bleeding, and would further evaluate. The resident would be asked if they had any pain, dizziness, if they were light headed, and had nausea, and then if everything was ok the resident would be positioned where they would like to be in the resident room. Per Staff A they would document, would fill out an Incident Report and Health Status Note. They would evaluate if the resident hit their head, and if that was the case, then neurological evaluations would begin. Staff A explained this would be included in the Health Status Note. The physician would be faxed about the situation to see if there were any new orders, and the family notification would be completed. Per Staff A one of the Administrators would be notified of the new injury via call if they were present or via email if they were not present at the facility, if it was very severe they would be called at home and informed of the situation.</p> <p>On 8/05/21 at 11:39 AM, the Director of Nursing (DON) was queried as to the process nursing staff followed if a resident was found with an injury of unknown origin. The DON explained it would depend on the injury, the injury would be treated first, and the cause would try to be determined. When queried who staff should tell in this situation, the DON responded the information would be passed through report. The DON further explained they would be notified if someone had a fall or more of a major injury, and staff were not asked to notify every time there was a skin tear. The DON acknowledged if there was a brand new injury without a determined cause an Incident Report should be completed. Per the DON, staff would reach out to herself or the Assistant</p>	F 610		

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F 610	<p>Continued From page 4</p> <p>Director of Nursing (ADON). The DON was queried as to the location of additional information for injuries of unknown origin, and explained information would be in the Nurses Note or Incident Report. The DON explained the ADON reviewed the Incident Reports, and the DON reviewed the 24 hour reports and 72 hour reports.</p> <p>On 8/10/21 at 12:00 PM, the facility Administrator was queried regarding injuries of unknown origin, and explained staff would tell their nurse, the nurse would assess the injury and notify the nurse on call or the DON, and the nurse on call would notify the DON and she would call the Administrator. The Administrator acknowledged the nurse on call or the Director of Nursing should be notified with any injury of unknown origin. The Administrator acknowledged they could not speak specifically to the events, but staff may thought they had known where they had come from.</p> <p>A facility policy was requested pertaining to injuries of unknown origin. The DON returned and explained there was no specific policy for injury of unknown origin. Review of the facility's Abuse, Neglect and Exploitation policy dated 11/28/16 revealed the following definition of injuries of unknown source: "an injury should be classified as an injury of unknown source when BOTH of the following conditions are met: the source of the injury was not observed by any person or the source of the injury could not be explained by the resident: AND the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time."</p>	F 610			
F 657 SS=D	Care Plan Timing and Revision	F 657			

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F 657	<p>Continued From page 5 CFR(s): 483.21(b)(2)(i)-(iii)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and the facility failed to updated the Care Plan for 2 out of 5 residents reviewed (Resident #15 and #26). The facility reported a census of 52 residents.</p> <p>Findings Include:</p> <p>1. The Minimum Data Set (MDS) Assessment for</p>	F 657			

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F 657	<p>Continued From page 6</p> <p>Resident #15 dated 7/28/21, listed diagnoses of heart failure, and coronary artery disease (CAD). The MDS further listed the Resident with a Brief Interview for Mental Status (BIMS) as a 5 indicating severely impaired cognition.</p> <p>The Care Plan for Resident # 15 dated 7/28/21, failed to identify the resident on a blood thinning medication and failed to direct staff to monitor for adverse effects of the medication.</p> <p>The Physician Order dated 6/29/21, read Eliquis (blood thinning medication) 5 milligrams (mg) two times a day.</p> <p>Observation on 8/04/21 at 08:56 AM, Resident #15 walked independently with his walker on the South hall.</p> <p>2. The Minimum Data Set (MDS) Assessment for Resident #26 dated 6/10/21, included diagnoses of Alzheimer's disease and dementia with behavioral disturbance. The MDS reflected the resident with short and long term memory problems and severe difficulty in daily decision making skills.</p> <p>The Care Plan for Resident #26 dated 3/2/21, identified the resident is at risk for alteration in psychosocial well being related to restriction on visitation due to Coronavirus Disease 2019 (COVID-19). The Care Plan directed staff to monitor for psychosocial changes, observe and report changes in mental status/mood due to situational stressors, provide increased opportunity for 1-1 staff interaction as needed, and provide opportunity for expression of feelings related to situational stressors</p>	F 657		

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F 657	Continued From page 7  The Behavior Note dated 5/17/2021 at 3:07 PM, read Resident #26 observed by male Certified Nurses Aid (CNA) holding a fork to his neck. CNA approached, Res stated "I just want to die". CNA able to pull the Resident's hand away from neck. Res. Had 2 small areas noted where fork punctured skin and 2 small drops of blood noted. The note continued the Resident reported he felt sad that he is not with his family. The note documented the resident's wife also stated the resident historically walked several miles per day to release his emotions and he hasn't been able to walk to this extent since admission. Staff provided 1:1 until appointment the next day.  The Care Plan Note dated 6/1/2021 at 1:47 PM, read the Resident continued on Celexa (antidepressant) since admission. The Physician discontinued the Wellbutrin (antidepressant) after the incident and scheduled an appointment with Geriatric Psych. The note continued Resident #26's anxiety increased during evening hours, the resident's wife and children calmed the resident down.  Behavior Note 6/27/2021 at 3:43 PM, read Resident # 26 is distressed through most of morning. The resident became very upset about word finding issues. Through conversation, Resident # 26 indicated he had not spoken to any family members in at least 5 days. The resident stated, "If my life is going to be like this, I just want to kill myself. I used to be a physician and I know how it goes. I just can't do this." Another statement resident made was, "Everyone (meaning staff) is running around taking care of a lot of people. I am not a bad person. I have never punched anyone. I don't know why everyone is	F 657			

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F 657	<p>Continued From page 8</p> <p>mad at me." The note continued to reflect the resident yelled at Certified Nurses Aid (CNA) with stern eyes, "She told you hello!"</p> <p>The Physician's Telephone Order dated 7/3/21, directed sertraline (antidepressant) 50 milligrams (mg) daily, and trazadone (antidepressant) 12.5 mg to 25 mg three times daily as needed for breakthrough anxiety. The order further read continue trazadone 25 mg nightly for sleep.</p> <p>The Care Plan revision dated 8/2/2, failed to address the resident use of an antidepressant medication and failed to address behaviors identified in the Progress Notes of suicidal thoughts.</p> <p>Observation on 8/04/21 at 12:40 PM, Resident #26 sat in the dining room at the table eating with another resident.</p> <p>Interview on 8/4/21 at 2:08 PM, Staff I, Restorative Aid, reported staff know how to take care for a resident by what is in the Care Plan. Staff I stated with Resident #26 they alert each other when he is up on the move for elopement risk. Staff I continued to state Resident #26 reported he had some dark thoughts we watch for.</p> <p>Interview on 8/09/21 at 3:03 PM, Staff G, Care Plan Coordinator, reported a medication is addressed on the Care Plan as an intervention, to provide medication per order. Staff G stated she expected the nurses to know what side effects to monitor for.</p> <p>Interview on 8/09/21 at 4:05 PM, Staff H Social Services, reported she puts a note in the</p>	F 657		

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F 657	Continued From page 9 progress notes, but Care Plan Coordinator is in charge of the Care Plan. Staff H stated she reaches out to family, and resident's, and puts a note in the chart, but doesn't do anything with the Care Plan.  Interview on 8/09/21 at 4:09 PM, the Assistant Director of Nursing (ADON) confirmed the Care Plan should address a resident wanting to hurt them self.  Interview on 8/10/21 at 11:15 AM, the Director of Nursing (DON) reported her execution is the nurses know, or look up the side effects of a medication in a drug book for what to monitor for. The DON revealed her expectation is all the staff who complete the Care Plan, update the Care Plan.  Interview on 8/10/21 at 11:18 AM, the Administrator reported her expectation is the Care Plan addresses a resident's comments of self harm.  The policy titled Comprehensive Care Plans dated 9/30/2020, directed at point # 5- the Comprehensive Care Plan will be reviewed and reviewed by the Interdisciplinary Team after comprehensive and Quarterly MDS Assessment. Point # 6- included Alternative intervention will be documented as needed.	F 657			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689			

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F 689	<p>Continued From page 10</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to investigate root cause of residents falls, and implement targeted interventions to reduce reoccurrence of falls, for two of seven residents investigated for falls. (Resident #23 and #47). The facility reported a resident census of 52.</p> <p>Findings Include:</p> <p>1. The Quarterly Minimum Data Set (MDS) dated 4/14/21 documented Resident#47 had diagnoses including hip fracture, anxiety disorder, cognitive communication deficit, dementia, and seizure disorder. The MDS revealed the resident scored a 4 out 15 for Brief Interview for Mental Status, which is severely impaired skills with daily decision making. The MDS documented that the resident required limited assistance of one staff for transfers, walking, toilet use, and personal hygiene. The MDS documented that the resident had a history of two falls in the last three months without injury.</p> <p>Upon review of the Incident Reports for the time period 2/19/21 to 7/24/21 the resident had ten falls, all of which were located in her room. Four of the ten Incident Reports documented that the resident fell between 10:00 p.m. and 11:30 p.m. Five of the ten falls described the resident as being on the floor near the bed. The Care Plan included one intervention for the time period reviewed, with the initiated date of 6/8/21 that</p>	F 689			

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F 689	<p>Continued From page 11</p> <p>directed staff as follows; gait belt, walker and assist of two with transfers. The Care Plan and the Incident reports lacked targeted interventions to help prevent the reoccurrence of falls for the resident.</p> <p>Incident Note 6/17/21 with time of 2:15 p.m. documented that the resident had frequent safety checks in place. The Care Plan lacked this as an intervention.</p> <p>The Morse Fall Scales dated 1/12/21, 4/19/21, and 7/07/21 documented the score of 90. The Instructions documented as follows; Fall Risk is based upon fall risk factors and it is more than a total score. Determine fall risk factors and target interventions to reduce risks. Complete on admission, quarterly, at change of condition, and after a fall.</p> <p>On 8/02/21 at 10:26 a.m. the resident laid in bed with soft music playing, two small upper side rails had been up towards the head of the bed, and call light in reach of the resident.</p> <p>On 8/04/21 at 12:20 p.m. the resident asleep in her bed, two small upper side rails up on bed towards the head of the bed, and call light within reach of the resident.</p> <p>On 8/04/21 at 2:35 p.m. the resident asleep in her bed small bedrails up on bed towards the head of the bed, with bed in lower position.</p> <p>On 8/9/21 at 2:10 p.m., the Assistant Director of Nursing (ADON) reported that interventions that would help the resident are talking with people, but the resident does get angry when people are in her room at times, but does enjoy visits from a</p>	F 689			

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F 689	<p>Continued From page 12 dog.</p> <p>On 8/09/21 at 3:03 p.m. Staff I, Restorative Aide reported that the resident had a low bed, and floor mats in place for fall prevention.</p> <p>Upon review of the Care Plan it lacked documentation of an intervention for a low bed, and floor mats.</p> <p>Review of the Care Plan interventions did not address all of the falls during the time period reviewed.</p> <p>The clinical record lacked a thorough resident centered investigation to assist in reducing the reoccurrence of falls for the resident.</p> <p>During an interview on 8/10/21 at 12:19 p.m., the Director of Nursing (DON) reported that she agreed that the Care plan team needs to work on communication as well as assessing the falls better, and working on interventions.</p> <p>The Comprehensive Care Plan Policy dated 9/30/20 directed staff to review and revise with the Interdisciplinary Team after each Comprehensive and Quarterly MDS Assessment, and alternative interventions will be documented as needed.</p> <p>2. The Minimum Data Set (MDS) Assessment dated 5/22/21 revealed Resident #23 rarely to never understood, had severely impaired cognition, and had short term and long term memory problems. The MDS also revealed Resident #23 required the extensive assistance of two plus persons physical assist for bed mobility, required limited assistance of one</p>	F 689		

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F 689	<p>Continued From page 13</p> <p>person physical assist for transfers, had two or more falls since admission or prior assessment with no injury, and had two or more falls since admission or prior assessment with injury (except major).</p> <p>A "MORSE FALL SCALE" Quarterly Assessment dated 4/21/21 identified Resident #23 at high risk for falling and scored an 80.0 on the assessment. It was noted a high risk score was categorized as 45 or higher.</p> <p>Review of thirteen Incident Reports for Resident #23 documented thirteen falls between 3/2/21 and 7/26/21. Incident reports documented eleven unwitnessed incidents and two witnessed incidents for the time period. Six incidents had occurred in the South Hall per the reports, and seven incidents had occurred in the resident's room. Dates of the incidents were as follows: 3/2/21 (two incidents), 3/23/21, 4/30/21, 5/6/21, 5/7/21, 6/7/21, 6/12/21 (two incidents), 6/16/21, 6/20/21, 7/12/21, and 7/26/21.</p> <p>The Care Plan for Resident #23 dated 4/16/19 revealed the following:</p> <ol style="list-style-type: none"> <li>Resident has potential For Falls, Poor Balance.</li> <li>Altered Comfort.</li> <li>Altered Sleep.</li> </ol> <p>The Care Plan also included the following five interventions added in 2021:</p> <ol style="list-style-type: none"> <li>Gait belt assist x 1, no walker, use bed rail and arm rests of chair for transfers (initiated 2/24/21, revised 5/27/21), wheelchair to toilet, use grab bar, assist x 1.</li> <li>Assist x 1 for hygiene and clothing management (initiated 2/24/21, revised 5/27/21).</li> <li>Administer analgesics as ordered/needed.</li> </ol>	F 689		

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F 689	<p>Continued From page 14</p> <p>APAP (initiated 4/14/21, revised 4/19/21).</p> <p>d. Keep wheelchair next to bed with brakes locked (initiated 5/27/21).</p> <p>e. Provide elevated sided pressure relieving mattress (initiated 6/17/21).</p> <p>Review of the Care Plan interventions failed to address all of Resident #23's falls during the time period.</p> <p>The Incident Report dated 3/2/21 at 11:00 AM documented an unwitnessed event occurred in the resident room. The Incident Description documented: Hope Dining Room staff member alerted this Nurse that the resident scooting on floor at entrance of her room. Her wheelchair noted to be within reach and the resident stated, "I'm hungry."</p> <p>The Incident Report dated 3/2/21 at 12:20 PM, revealed an unwitnessed event occurred in the South Hall. The Incident Description documented: Certified Nursing Assistant (CNA) alerted this Nurse that the resident was lying down on her left side at the foot of a nearby wheelchair.</p> <p>The Incident Report dated 3/23/21 at 10:00 AM, revealed an unwitnessed event occurred in the resident room. The Incident Description documented: resident noted to be awake and scooting outside of her room, stating she was hungry.</p> <p>The Incident Report dated 4/30/21 at 5:19 PM, revealed an unwitnessed event occurred in the South Hall. The Incident Description documented: Around 4:50 PM, CNAs heard a loud noise while in another resident's room. Came out by South Hall tables and noted the resident lying supine on</p>	F 689			

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F 689	<p>Continued From page 15</p> <p>the floor. They notified this nurse immediately. Blood noted to be pooling from a wound to the back of the resident's head.</p> <p>The Incident Report dated 5/6/21 at 5:18 PM, documented an unwitnessed event occurred in the resident's room. The Incident Description documented: Around 4:50 PM, a CNA reported that the resident was on the floor/mat beside her bed. The nurse arrived to note the resident lying supine with her head up between the side table and bed, while the rest of her body was on the mat beside the bed.</p> <p>The Incident Report dated 5/7/21 at 1:15 PM, documented an unwitnessed event occurred in the resident's room. The Incident Description documented: Resident seen on the mat on the floor next to her bed by CNA. Called the nurse.</p> <p>The Incident Report dated 6/7/21 at 6:58 AM, revealed an unwitnessed event occurred in the South Hall. The Incident Description documented: Staff walked past resident's room and seen that she was out of bed and staff assisted resident back into bed.</p> <p>The Incident Report dated 6/12/21 at 2:56 AM, documented an unwitnessed event took place in the resident room. The Incident Description documented: Nurse was performing rounds after getting report, was checking on resident when seen her bed was empty, the nurse walked into the resident's room and noted the resident sitting on floor. Staff assisted resident into a wheelchair and brought her out to the commons area.</p> <p>A Behavior Note dated 6/12/21 at 8:50 AM, documented: Resident awake and active this</p>	F 689		

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F 689	<p>Continued From page 16</p> <p>a.m. attempting to get in and out of bed, in and out of her wheelchair. 1:1 provided as much as possible. Resident noted spitting, hitting, kicking nursing staff with cares and medication pass.</p> <p>The Incident Report dated 6/12/21 at 9:45 AM, documented a witnessed fall in the South Hall. The Incident Description documented: Nurse caught the resident while she self-transferred out of her wheelchair in the South Common Area; called for help. The resident noted restless and stated wanting to go home.</p> <p>The Behavior Note dated 6/15/21 at 11:26 PM, documented: Resident noted to have increased agitation and restlessness. Frequently attempting to get out of bed or her wheelchair when up. She ate some food and took her medications, but was notably combative with staff (attempting to hit, kick, bite, etc.). After getting some rest the resident's combativeness decreased somewhat, but she remained combative when staff would attempt to prevent her from standing/self-transferring from her wheelchair. Resident is currently sitting up in her wheelchair quietly near south hall tables.</p> <p>The Incident Note dated 6/16/21 at 2:15 AM, documented: Resident in reclaim chair sleeping, when nurse heard the resident call for help. Nurse turned head and saw resident lying on the floor in the South Hall. Nurse went to help resident and saw resident head and hair had blood. Nurse called nurse on North Hall for help.</p> <p>The Incident Report dated 6/16/21 at 2:15 AM, documented a witnessed fall in the South Hall. The Incident Description documented: At around 2:15 AM, call from South Hall Nurse needing help</p>	F 689		

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F 689	<p>Continued From page 17</p> <p>cause resident had fallen out of her chair and hit her head on the floor. North Nurse went over to South and saw resident sitting up on floor with blood smears on the floor from back of resident's head. Assessed back of resident's head and what appeared to be a laceration that would potentially require sutures or staples. South nurse and South CNA stayed with resident and held pressure to back of head.</p> <p>The Incident Report dated 6/20/21 at 12:15 AM, documented an unwitnessed event in the South Hall. The Incident Description documented: CNA called nurse to South Hall tables for assistance. Upon returning the resident laying on the floor next to table with wheelchair beside her. The resident had a small laceration to the left side of her forehead approximately 2 cm in length with some discoloration surrounding it. The laceration bleeding and bled back into resident's hair. No other injuries noted, assisted the resident back into the wheelchair with CNA assist. Resident required constant 1:1 attention throughout the shift.</p> <p>The Incident Report dated 7/12/21 at 2:20 PM, documented an unwitnessed event in the resident room. The Incident Description documented: Nurse summoned to room and the resident noted to be scooting on the floor off bedside floormat. With 2 assist and use of soft gait belt returned resident to safety of her wheelchair, then brought out into South Common Area to monitor.</p> <p>The Health Status Note dated 7/26/21 at 3:25 PM, documented: Afebrile and somewhat restless at times, but for most part, the resident rested in her wheelchair and recliner this shift out in the South Common Area to provide 1:1/ close</p>	F 689			

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F 689	<p>Continued From page 18</p> <p>monitoring. Housekeeper noted resident sitting on wheelchair pedals.</p> <p>The Incident Report dated 7/26/21 at 3:26 PM, revealed an unwitnessed event in the resident room. The Incident Description documented: Housekeeper noted there resident sitting on the wheelchair pedals. Assist of two staff with use of soft gait belt back into safety of wheelchair and no injuries observed.</p> <p>Observation on 8/02/21 at 10:25 AM, revealed Resident #23 was seated in a high back wheelchair. Resident #23 stated, "Did I have my dinner?"</p> <p>On 8/04/21 at 1:13 PM, Staff C, Certified Nursing Assistant (CNA), was queried in regard to Resident #23, and explained the resident moved a lot up and down in the bed and the wheelchair. Staff C explained they tried to keep someone with the resident at all times. Per Staff C the resident was not able to use the call light and had days and nights mixed up. Staff C explained everyone assisted as staff were busy, and nurses and Recreation Aides assisted with as much time as they could.</p> <p>On 8/04/21 at 1:31 PM, Staff D, CNA, was queried in regard to Resident #23. Staff D explained the resident could understand the staff if they were within six inches of her ear. Staff D was queried whether the resident liked to get up and down, and responded that she had witnessed this approximately twenty minutes ago. Staff D further explained the resident would stand up to reach for anything if it was on the table within reaching distance.</p>	F 689		

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F 689	<p>Continued From page 19</p> <p>On 8/04/21 at 4:41 PM, Staff E, Registered Nurse (RN), was queried in regard to Resident #23 and explained, in part, the resident was very frequently confused and often restless which could lead to Resident #23 being combative at times. Staff E explained Resident #23 may be calmed down by going for walks around the unit and often when the resident's children came it calmed the resident.</p> <p>On 8/09/21 at 2:10 PM, the facility's Assistant Director of Nursing (ADON) was queried as to how they became aware of falls, and responded this was communicated via email or when they read report. The ADON explained they read report every day and reviewed resident Progress Notes. Next, the ADON would make sure the Incident Report was filled out completely, and would also follow to see if there were any injuries or skin issues. The Incident Report would usually be closed out, and nurses would usually get ahold of the doctor if there were any skin issues. After that, skin would be followed weekly and the ADON further explained there should be charting daily if there was a treatment. The treatment would be completed until the area was healed. The ADON was queried as to interventions implemented post fall to prevent reoccurrences, acknowledged staff were involved in the process, and further explained this would be reviewed every 90 days with the Care Plan review or if there was another issue or something which required follow up. The ADON was queried as to next step followed if the intervention was not working, explained the intervention would be changed, and communication would occur with the doctor to obtain their thoughts. The ADON was queried as to whether they looked for patterns with falls, and acknowledged they were</p>	F 689		

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F 689	<p>Continued From page 20 always looking for patterns.</p> <p>On 8/09/21 at 2:23 PM, the facility's ADON was further queried about participation in the Falls Meeting, explained they were not in on the Fall Meeting, and further explained usually it was someone else and two Restorative Aides. The ADON explained they were not the person that did all the fall interventions, and identified the individual responsible as Staff G (Care Plan Coordinator). The ADON identified Staff G as responsible for fall interventions and identifying trends. Per the ADON if a new intervention was implemented the ADON would add it to the plan of care, otherwise a discussion would occur. The ADON explained interventions attempted before a fall would usually be documented, and usually in the Nurses Notes it would be documented what had been tried or what interventions were attempted prior to administering medication.</p> <p>The ADON was queried about interventions for Resident #23, and explained one to one supervision with someone walking and/or sitting with the resident had been effective. The ADON further explained there were Recreation Aides that would walk with the resident, sit with her, and whoever had time would assist. The ADON acknowledged with one to one supervision for Resident #23 the resident would still display behaviors, however the resident was less likely to fall out of the chair.</p> <p>On 8/09/21 at 2:50 PM, Staff G, Care Plan Coordinator was queried about their involvement in the falls process. Staff G explained they completed care plans for skilled residents. Per Staff G, the ADON would go through the incident reports every month as they occurred, and when</p>	F 689		

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F 689	<p>Continued From page 21</p> <p>the ADON saw that a resident had fallen then they would review the incident report. Staff G explained they (Staff G) would review the fall incident reports at the end of the month, and a discussion would occur with restorative staff to try to brainstorm interventions. Staff G explained they would look to see what the nurses and the ADON had already put in place, and stated that for some people no matter what you do it did not seem to help much. Staff G was queried if each fall would have a new intervention on the plan of care, and acknowledged that it would depend. Staff G acknowledged sometimes it got to the point where there was nothing else that could be thought of to do. Staff G explained the ADON would probably put new information on the plan of care, unless it was an intervention implemented by Staff G and Restorative Aides. If the intervention had been implemented by Staff G and the Restorative Aides, then Staff G acknowledged she would probably put it on the plan of care.</p> <p>Staff G was queried regarding Resident #23's falls, and the staff member explained most falls were related to the resident crawling out of bed. When queried about trends in the resident's falls, Staff G explained as the resident's cognition got worse, the resident got very very restless. Staff G further explained Resident #23 would want to go to bed, the resident would be assisted to lay down, and it would not be two minutes until the resident wanted to get up. Per Staff G Resident #23 required a lot of one to one (supervision) as the resident progressed with the disease process.</p> <p>On 8/09/21 at 3:03 PM, Staff I, Restorative Aide was queried in regard to fall meetings, and acknowledged the frequency of the meeting was</p>	F 689			

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NAME OF PROVIDER OR SUPPLIER  <b>OAKNOLL RETIREMENT RESIDENCE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1 OAKNOLL CT IOWA CITY, IA 52240</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	<p>Continued From page 22</p> <p>once per month. Staff I explained themselves, the ADON, Staff G, Staff J, Restorative Aide, and sometimes the DON would go through all falls that had happened in the last quarter and they would brainstorm interventions. Staff I was queried if an intervention would be implemented for each fall, and responded "They sure try. I would say yes."</p> <p>Staff I was queried about Resident #23's falls, and explained when the resident was on the floor it was considered a fall. Staff I explained the resident would slide, and when the resident was assisted to bed and she did not want to be there the resident would squirm right out of the bed to the hall. Per Staff I the resident was checked more frequently than a lot of other people. Staff I further queried as to which interventions were particularly effective in preventing additional falls for the resident, and explained they could not honestly say other than putting the resident's bed on the floor.</p> <p>The facility policy titled Accidents and Incidents-Investigating and Reporting last revised 1/14/21 documented: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Director of Health Services and the Administrator.</p> <p>The policy further explained, the Nurse Supervisor/Charge Nurse and/or the Department Director or Supervisor shall promptly initiate and document investigation of the accident or incident. The following data, as applicable, shall be included on the Report of Incident/Accident form for visitors, employees, venders, etc..</p>	F 689		

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

PRINTED: 08/17/2021  
FORM APPROVED  
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F 689	Continued From page 23 For residents document the following in Power chart on the Post Fall Assessment: a. The date and time the accident or incident took place. b. The nature of the injury/illness (e.g., fall, incidents of injury etc.). c. The circumstances surrounding the accident or incident. d. Where the accident or incident took place. e. The name(s) of witnesses and their accounts of the accident or incident. f. The injured person's account of the accident or incident. g. The time the injured person's Attending Physician was notified. h. The date/time the injured person's family was notified and by whom. i. The condition of the injured person, including his/her vial signs. j. The disposition of the injured (i.e., transferred to hospital, put to bed, sent home, returned to work, etc.). k. Any corrective action taken. l. Follow-up information. m. Other pertinent data as necessary or required. n. The signature and title of the person completing the report.	F 689			

Plan of Correction  
Oaknoll Retirement Residence  
165030

	Survey dates 8/2/21-8/10/21		Correction Date: 8/27/2021	
F000	<p><b>INITIAL COMMENTS:</b></p> <p>The following deficiencies relate to the Recertification Survey and investigation of Complaint #98852 and a Facility Self-Reported Incident #99045 conducted on 8/2/21 to 8/10/21. Complaint #98852-C was partially substantiated, and Incident #99045 was substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).</p>	F000	<p><i>This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, the submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.</i></p>	8/27/21
F610 SS=D	<p>Investigate/Prevent/Correct Alleged Violation</p> <p>CFR(s): 483.12(c)(2)-(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F610	<p><i>Based on record review, observation, and staff interviews the facility failed to ensure identified areas of skin impairment with unknown etiology were thoroughly investigated for 1 of 1 resident reviewed for injuries of unknown origin. The facility reported a census of 52 residents.</i></p> <p>Administrator to review and clarify the wording of the abuse policy immediately and share copy with surveyor.</p> <p>Administrator and DON will communicate any changes to all staff via email.</p> <p>DON will refresh education to nurses during nurse's meeting and via email on care plan/MDS communication, investigation of all injuries, including root cause analysis, and reporting requirements per the abuse policy. Cause of injury must be identified on incident report and/or in nursing progress notes.</p> <p>Resident report reviewed by DON or designee to ensure nursing staff are following the abuse policy.</p> <p>DON or designee will send monthly report to Administrator including resident name, incident, injury, root cause analysis, and injury/fall prevention interventions implemented.</p>	<p>8/9/21</p> <p>8/9/21</p> <p>8/25/21</p> <p>8/9/21</p> <p>8/27/21</p>
F657	Care Plan Timing and Revision			

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<p><b>SS=D</b></p>	<p>CFR(s): 483.21(b)(2)(i)-(iii)</p> <p>§483.21(b) Comprehensive Care Plans</p> <p>§483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p>	<p>F657</p>	<p><i>This REQUIREMENT is not met as evidenced by:</i></p> <p><i>Based on observations, record review and the facility failed to update the Care Plan for 2 out of 5 residents reviewed (Resident #15 and #26).</i></p> <p><i>The facility reported a census of 52 residents.</i></p> <p>Refresh education on Care Plan/MDS Communication and Process via webinar for all members of ID team plus Administrator and DON from LAI Nurse Consultant, Kellie Van Ree.</p> <p>Review all current care plans to ensure compliance immediately.</p> <p>Random Care Plan audits by DON each month for three months and then quarterly ongoing.</p>	<p>8/27/21</p> <p>8/27/21</p> <p>8/27/21</p>
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<p><b>F689</b> <b>SS=D</b></p>	<p><b>§483.25(d) Accidents.</b></p> <p>The facility must ensure that -  <b>§483.25(d)(1)</b> The resident environment remains as free of accident hazards as is possible; and <b>§483.25(d)(2)</b>. Each resident receives adequate supervision and assistance devices to prevent accidents.</p>	<p><i>Based on observation, record review and staff interviews, the facility failed to investigate root cause of residents falls, and implement targeted interventions to reduce reoccurrence of falls, for two of seven residents investigated for falls. (Resident #23 and #47). The facility reported a resident census of 52.</i></p> <p>Refresh education to Nurses on investigation, root cause analysis, and targeted fall prevention interventions</p> <p>Education on fall prevention, investigation, root cause analysis, and targeted fall prevention interventions on hire and annually</p> <p>Expand Fall Prevention Committee to include DON, ADON, MDS/SNF, and Restorative team.</p> <p>Increase frequency of Fall Prevention Committee from monthly to weekly.</p> <p>Include staff from each shift and communicate to all staff via email.</p> <p>Fall report to Administrator monthly to include resident, falls, root cause, interventions.</p> <p>Refresh Nurses on the requirement to notify DON, or designee of any injury.</p> <p>Review fall/injury prevention/investigation policy and communicate to all staff now and annually.</p>	<p>8/25/21</p> <p>8/10/21</p> <p>8/10/21</p> <p>8/10/21</p> <p>8/10/21</p> <p>8/25/21</p> <p>8/25/21</p> <p>8/10/21</p>
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