STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165313	A. BUILDING _____ B. WING _____	C 02/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD SPECIALTY CARE	200 16TH AVENUE EAST ALBIA, IA 52531

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 2-24-17 Complaint #64711-C and Incidents #64923-I, #64619-M and #65062-A were investigated December 28, 2016-February 13, 2017. The following deficiencies relate to the Code of Federal Regulations (42-CFR) Part 483, Subpart B-C.	F 000	See attached	
F 223 SS=G	483.12 FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. This REQUIREMENT is not met as evidenced by: The following deficiency relates to facility self report 64923-I. Based on observations, record review, staff interviews and resident interview, the facility failed to ensure 2 of 11 residents (Residents #11 and 10) remained free from abuse by Resident #9. The facility reported a census of 53 residents. Findings include: The facilities "Dependent Adult Abuse" policy updated 5/16 section revealed each resident had the right to be free from abuse. The policy indicated Residents must not be subjected to	F 223		

2/27/17 TDW

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/23/2017

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 223	Continued From page 1 abuse by anyone including but not limited to other residents. Mental abuse included but not limited to harassment. When resident to resident sexual harassment, sexual coercison, or sexual assault is also considered abuse. The facility will presume that instance of abuse caused physical harm, pain or mental anguish in residents with cognitive and or physical impairments which may result in a resident unable to communicate physical harm, pain or mental anguish in the absence of evidence to the contrary. The policy listed an example of a resident slapping another resident who is physical or cognitively impaired even though the resident showed no reaction; it is presumed the resident experienced pain. The policy for resident to resident altercations indicated the facility will do whatever possible to control resident to resident altercation in order to prevent mental, physical, sexual and verbal abuse from occurring. 1.According to the Face Sheet for Resident #11, he/she had current diagnoses of anxiety disorder, recurrent depressive disorders, mood disorder, and chronic kidney disease. The incident report dated 12/15/16, the aides found another resident (Resident #9) inside Resident #11's room. The other resident had removed Resident #11's penis from his/her pants and was playing with it. Resident #11 had been resting in bed with his/her eyes closed. Nurse's Notes dated 12/15/16 at 1:25 a.m. Resident #9 was found in a room across the hall sitting in his/her wheelchair next to the bed of Resident #11. Resident #9 was exposing his/her genitals and had exposed the genitals of	F 223		

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F 223	Continued From page 2	F 223		

Resident #11 and was fondling Resident #11's genitals. Resident #11 remained asleep with his/her eyes closed. Resident #9 removed from the room immediately stated, "Leave us alone, we're two adults and can do what we want". Resident #9 taken to room and provided 1:1 supervision. Resident #9 masturbating in front of staff and asking staff if they "wanna [expletive]". At 3:25 p.m. Resident #9 was transferred out of facility and sent to an inpatient mental health facility for evaluation.

Nurse's Notes dated 12/20/16 at 8:07 a.m. Resident #9 returned to facility. Resident #9 was placed on 15 minute checks and on 12/29/16 at 8:20 p.m. 15 minute checks were discontinued.

2. According to the Minimum Data Set (MDS) assessment with assessment reference date of 11/16/16, Resident #10 had a Brief Interview for Mental Status (BIMS) score of 11 indicating moderately impaired cognitive abilities. Resident #10 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #10's diagnosis included Non Alzheimer's dementia, malnutrition and depression.

Nurse's Notes dated 1/1/17 at 10:50 p.m. Resident #9 was observed in Resident #10's room fondling Resident #10's genitals. Residents were immediately separated and Resident #9 placed on 15 minute checks.

In an interview on 1/5/17 at 11:10 a.m. Resident #10 stated a few days ago a resident (Resident #9) kept coming to his/her door and staring at him/her. Finally the other evening (1/1/17) Resident #9 entered his/her room and grabbed

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F 223	Continued From page 3	F 223		

his/her genitals and started to "go down" on him/her. Resident #10 told the resident to stop. Resident #9 then grabbed Resident #10's hand and placed it on Resident #9's genitals while Resident #9 fondled Resident #10's genitals. Finally a male aide (Staff A) came in and stopped it. Resident #10 stated he/she is still upset and afraid and didn't know what to do. Resident #10 denied inviting Resident #9 into his/her room.

In an interview on 1/4/17 at 5:15 p.m. Staff A, certified nurse aide, stated upon arriving to work for his overnight shift on 1/1/17 he noticed Resident #9 sitting in his/her wheelchair a the nurse's station. Staff A stated Resident #9 was to be either at the nurse's station or in his/her room because of an incident which occurred a few weeks ago. Staff A stated he answered a call light and when he returned to the nurse's station Resident #9 was no longer there. Staff A stated he began looking for Resident #9 and found him/her sitting in his/her wheelchair at the bedside of Resident #10. Resident #10's covers and brief had been pulled back and Resident #9 was fondling Resident #10's genitals.

In an interview on 1/5/17 at 12:05 a.m. Staff B, licensed practical nurse, stated she was charting at the nurse's station at the end of her shift (2:00 p.m. to 10:00 p.m.) on 1/1/17. Resident #9 had been sitting at the nurse's station, but at some point left unnoticed by Staff B. A few minutes later, Staff B propelled Resident #9 to the nurse's station and reported Resident #9 was discovered in Resident #10's room touching him/her inappropriately. Staff B stated she was aware of Resident #9's history of behaviors, but noted there was no formal expectation of supervision.

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F 223	Continued From page 4 In an interview on 1/5/17 at 10:08 a.m. Staff C, licensed practical nurse, stated on the evening of 1/1/17 she arrived to work at 9:45 p.m. Resident #9 was sitting in his/her wheelchair at the nurse's station. Staff C stated she and other nurses started to make rounds and she instructed aides standing at the nurse's station to keep an eye on Resident #9. Staff C stated Staff A had not arrived to work yet. Sometime after 10:00 p.m. as they returned to the nurse's station, Staff A had propelled Resident #9 to the nurse's station and reported there had been an incident . Staff C stated she was aware of earlier incidents involving Resident #9 being sexually inappropriate, but noted he/she had been good with no inappropriate behaviors since his/her hospitalization. Staff C stated Resident #9 was to be in line of site when in his/her wheelchair and required no additional supervision if in a straight back chair. In an interview on 1/5/17 at 2:45 p.m. Staff D, licensed practical nurse, stated he worked the 2:00 p.m. to 10:00 p.m. shift on 1/1/17. At around 10:00 p.m. he was giving report and counting narcotics with the on-coming nurse. Resident #9 had been sitting in his/her wheelchair at the nurse's station, but had slipped away. Staff A discovered Resident #9 in the room of Resident #10 touching his/her genitals. Staff D stated he was not assigned to Resident #9 that evening and wasn't certain of his/her supervision status. Staff D stated Resident #9 was not on 1:1 supervision or even line of sight supervision. In an interview on 1/5/17 at 2:26 p.m. Staff E, certified nurse aide, stated she worked the 2:00 p.m. to 10:00 p.m. shift on 1/1/17 on hall 2. Staff E stated she knew of some history involving	F 223		

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F 223	Continued From page 5 Resident #9, but was not assigned to his/her hall. Staff E stated she was unaware of the incident in which Resident #9 was discovered touching Resident #10 at shift change. In an interview on 1/5/17 at 2:37 p.m. Staff F, certified nurse aide, stated she worked the 2:00 p.m. to 10:00 p.m. shift on 1/1/17. Staff F stated she was aware of Resident #9 masturbating in the hallway, but was not aware that he/she had touched anyone inappropriately. Staff F stated she was not aware of the supervision status of Resident #9 and does not recall anyone telling her or other aides to keep an eye on Resident #9 at shift change 1/1/17. In an interview on 1/5/17 at 9:25 a.m. the Director of Nursing (DON) stated Resident #9 began having sexually inappropriate behaviors in mid-December. On 12/15/16, Resident #9 was discovered in Resident #11's room exposing his/her genitals and fondling Resident #11's genitals on 12/15/16. Resident #9 was hospitalized for evaluation at a mental health facility 12/15/16 through 12/20/16. Upon return to the facility he/she was placed on 15 minute checks. Following 9 days of no inappropriate behaviors, the 15 minute checks were discontinued (12/29/16). Then on 1/1/17 Resident #9 was discovered in Resident #10's room touching Resident #10 inappropriately. The DON stated they are now looking for alternative placement for Resident #9.	F 223		
✓ F 224 SS=G	483.12(a)(1) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN a) The facility must- (1) Not use verbal, mental, sexual, or physical	F 224		

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F 224	Continued From page 6 abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: The following deficiency relates to facility self report 64923-I. Based on record review, interviews, and facility policy, the facility failed to prevent occurrences and monitor for changes that would trigger abusive behavior to prevent Resident #9 from abusing Residents #11 and Resident #10. The facility reported a census of 53 residents. Findings include: The facilities "Dependent Adult Abuse" policy updated 5/16 section revealed each resident had the right to be free from abuse. The policy indicated Residents must not be subjected to abuse by anyone including but not limited to other residents. The policy for resident to resident altercations indicated the facility will do whatever possible to control resident to resident altercation in order to prevent mental, physical, sexual and verbal abuse from occurring. When resident to resident sexual harassment, sexual coercion, or sexual assault is also considered abuse. The facility will presume that instance of abuse caused physical harm, pain or mental anguish in residents with cognitive and or physical impairments which may result in a resident unable to communicate physical harm, pain or mental anguish in the absence of evidence to the contrary. Mental abuse included but not limited to harassment. The policy listed an example of a resident slapping another resident who is physical or cognitively impaired even though the resident showed no reaction; it is presumed the resident	F 224		

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F 224	Continued From page 7 experienced pain. 1. According to the Minimum Data Set (MDS) assessment with assessment reference date of 10/13/16, Resident #9 had a Brief Interview for Mental Status (BIMS) score of 8 indicating moderate impaired cognitive abilities. Resident #9 was independently mobile in his/her wheelchair and required extensive assistance with transfers, dressing, toilet use and personal hygiene needs. Resident #9's diagnosis included Non Alzheimer's dementia, multiple sclerosis and congestive heart failure. Nurse's Notes dated 12/13/16 at 6:40 p.m. Resident #9 observed with his/her genitals exposed and asking another resident if they wanted to play with it. Resident #9 instructed to cover self up and assisted back into wheelchair and propelled to his/her room. Nurse's Notes dated 12/14/16 at 7:45 p.m. Resident #9 observed masturbating in doorway of another resident's room. Resident witnessed behavior and yelled at Resident #9. Resident #9 educated on not exposing him/herself in public. Resident #9 moved to a different hallway room away from the other resident. At 7:50 p.m. Resident #9 was found attempting to enter the other resident's room and attempting to expose his/her genitals. Resident brought to nurse's station and then proceeded to masturbate in front of two staff members. Resident #9 was then propelled to room and placed in bed. Resident #9 combative and aggressive towards staff. Nurse's Notes dated 12/15/16 at 1:25 a.m. Resident #9 was found in a room across the hall sitting in his/her wheelchair next to the bed of	F 224		

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Resident #11. Resident #9 was exposing his/her genitals and had exposed the genitals of Resident #11 and was fondling Resident #11's genitals. Resident #11 remained asleep with his/her eyes closed. Resident #9 removed from the room immediately stated, "Leave us alone, we're two adults and can do what we want". Resident #9 taken to room and provided 1:1 supervision. Resident #9 masturbating in front of staff and asking staff if they "wanna [expletive]. At 3:25 p.m. Resident #9 was transferred out of facility and sent to an inpatient mental health facility for evaluation.

a. According to the Face Sheet for Resident #11, he/she had current diagnoses of anxiety disorder, recurrent depressive disorders, mood disorder, and chronic kidney disease.

Nurse's Notes dated 12/20/16 at 8:07 a.m. Resident #9 returned to facility. Resident #9 was placed on 15 minute checks and on 12/29/16 at 8:20 p.m. 15 minute checks were discontinued.

Nurse's Notes dated 1/1/17 at 10:50 p.m. Resident #9 was observed in Resident #10's room fondling Resident #10's genitals. Residents were immediately separated and Resident #9 placed on 15 minute checks.

b. According to the Minimum Data Set (MDS) assessment with assessment reference date of 11/16/16, Resident #10 had a Brief Interview for Mental Status (BIMS) score of 11 indicating moderately impaired cognitive abilities. Resident #10 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #10's diagnosis included Non Alzheimer's dementia, malnutrition

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F 224	Continued From page 9 and depression. In an interview on 1/5/17 at 11:10 a.m. Resident #10 stated a few days ago a resident (Resident #9) kept coming to his/her door and staring at him/her. Finally the other evening (1/1/17) Resident #9 entered his/her room and grabbed his/her genitals and started to "go down" on him/her. Resident #10 told the resident to stop. Resident #9 then grabbed Resident #10's hand and placed it on Resident #9's genitals while Resident #9 fondled Resident #10's genitals. Finally a male aide (Staff A) came in and stopped it. Resident #10 stated he/she is still upset and afraid and didn't know what to do. Resident #10 denied inviting Resident #9 into his/her room. Resident #9's plan of care indicated he/she has history of altercations with other residents including physical aggression, exposing self and inappropriately touching others. Approaches included periods of 1:1 supervision 12/15/16 to 12/20/16 and again on 1/3/17 to present, 15 minute checks 12/20/16 to 12/29/16 and 1/1/17 to 1/3/17 and an alarm outside of room 1/3/17. In an interview on 1/4/17 at 5:15 p.m. Staff A, certified nurse aide, stated upon arriving to work for his overnight shift on 1/1/17 he noticed Resident #9 sitting in his/her wheelchair a the nurse's station. Staff A stated Resident #9 was to be either at the nurse's station or in his/her room because of an incident which occurred a few weeks ago. Staff A stated he answered a call light and when he returned to the nurse's station Resident #9 was no longer there. Staff A stated he began looking for Resident #9 and found him/her sitting in his/her wheelchair at the	F 224		

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F 224	Continued From page 10 bedside of Resident #10. Resident #10's covers and brief had been pulled back and Resident #9 was fondling Resident #10's genitals. In an interview on 1/5/17 at 12:05 a.m. Staff B, licensed practical nurse, stated she was charting at the nurse's station at the end of her shift (2:00 p.m. to 10:00 p.m.) on 1/1/17. Resident #9 had been sitting at the nurse's station, but at some point left unnoticed by Staff B. A few minutes later, Staff B propelled Resident #9 to the nurse's station and reported Resident #9 was discovered in Resident #10's room touching him/her inappropriately. Staff B stated she was aware of Resident #9's history of behaviors, but noted there was no formal expectation of supervision. In an interview on 1/5/17 at 10:08 a.m. Staff C, licensed practical nurse, stated on the evening of 1/1/17 she arrived to work at 9:45 p.m. Resident #9 was sitting in his/her wheelchair at the nurse's station. Staff C stated she and other nurses started to make rounds and she instructed aides standing at the nurse's station to keep an eye on Resident #9. Staff C stated Staff A had not arrived to work yet. Sometime after 10:00 p.m. as they returned to the nurse's station, Staff A had propelled Resident #9 to the nurse's station and reported there had been an incident. Staff C stated she was aware of earlier incidents involving Resident #9 being sexually inappropriate, but noted he/she had been good with no inappropriate behaviors since his/her hospitalization. Staff C stated Resident #9 was to be in line of site when in his/her wheelchair and required no additional supervision if in a straight back chair. In an interview on 1/5/17 at 2:45 p.m. Staff D,	F 224		

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licensed practical nurse, stated he worked the 2:00 p.m. to 10:00 p.m. shift on 1/1/17. At around 10:00 p.m. he was giving report and counting narcotics with the on-coming nurse. Resident #9 had been sitting in his/her wheelchair at the nurse's station, but had slipped away. Staff A discovered Resident #9 in the room of Resident #10 touching his/her genitals. Staff D stated he was not assigned to Resident #9 that evening and wasn't certain of his/her supervision status. Staff D stated Resident #9 was not on 1:1 supervision or even line of sight supervision.

In an interview on 1/5/17 at 2:26 p.m. Staff E, certified nurse aide, stated she worked the 2:00 p.m. to 10:00 p.m. shift on 1/1/17 on hall 2. Staff E stated she knew of some history involving Resident #9, but was not assigned to his/her hall. Staff E stated she was unaware of the incident in which Resident #9 was discovered touching Resident #10 at shift change.

In an interview on 1/5/17 at 2:37 p.m. Staff F, certified nurse aide, stated she worked the 2:00 p.m. to 10:00 p.m. shift on 1/1/17. Staff F stated she was aware of Resident #9 masturbating in the hallway, but was not aware that he/she had touched anyone inappropriately. Staff F stated she was not aware of the supervision status of Resident #9 and does not recall anyone telling her or other aides to keep an eye on Resident #9 at shift change 1/1/17.

In an interview on 1/5/17 at 9:25 a.m. the Director of Nursing (DON) stated Resident #9 began having sexually inappropriate behaviors in mid-December. It was a change which started out with him/her exposing him/herself in the dining room on 12/13/16. This was followed by

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F 224	Continued From page 12 attempting to enter another resident's room with his/her genitals exposed on 12/14/16 and finally discovered in Resident #11's room exposing his/her genitals and fondling Resident #11's genitals on 12/15/16. Resident #9 was placed on 1:1 supervision and 15 minute checks. Resident #9 was hospitalized for evaluation at a mental health facility 12/15/16 through 12/20/16. Upon return to the facility he/she was placed on 15 minute checks. Following 9 days of no inappropriate behaviors, the 15 minute checks were discontinued (12/29/16). Then on 1/1/17 Resident #9 was discovered in Resident #10's room touching Resident #10 inappropriately. Resident #9 was placed back on 15 minute checks and on 1/3/17 was placed on 1:1 supervision at all times. An alarm was also added to Resident #9's door. The DON stated they are now looking for alternative placement for Resident #9.	F 224		
✓F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: The following deficiency relates to complaint 64711-C. Based on record review and staff interviews, the facility failed to follow a resident's plan of care	F 282		

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F 282	Continued From page 13 related to the use of a soft neck collar. (Residents #8) The facility reported a census of 53 residents. Findings include: According to the Minimum Data Set (MDS) assessment with assessment reference date of 10/19/16, Resident #8 had short and long term memory deficits and severely impaired cognitive abilities. Resident #8 required extensive assistance with transfers, dressing, toilet use and personal hygiene needs. The resident did not ambulate. Resident #8's diagnoses included schizophrenia, mild mental retardation and status post C4 neck fracture. Resident #8's current plan of care with onset date of 6/21/16 indicated he/she experiences occasional pain related to a C4 neck fracture with approaches which include using a soft collar at all times. In an interview on 2/13/17 at 10:00 a.m. Staff G, Certified Nurse Aide (CNA), stated on the evening of 11/22/16 she was giving Resident #8 a shower. She briefly went around a corner in the shower room to get a towel and as she returned within seconds, Resident #8 was leaning forward in the shower chair and falling out. Staff G attempted to slow the fall, but Resident #8 fell onto his/her face and knees. Staff G stated she used the blue call light to summon help. Staff G admitted she was not using the shower chair seat belt because she was told residents who are capable of sitting upright did not need a seat belt because it would be considered a restraint. Staff G stated she was told this by Staff H (CNA), who had trained her, but who no longer worked at the facility. Staff G also stated she had removed Resident #8's soft	F 282		

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F 282	Continued From page 14 neck collar during the shower. Staff G stated she believed it was acceptable to remove the collar during a shower and to get it back on once the resident was dried off. In an interview on 1/9/17 at 3:20 p.m. the Director of Nursing (DON), stated on 11/22/16 Resident #8 fell from the shower chair while being showered. Staff G was giving the shower and had failed to place the shower chair seat belt around the resident. Resident #8 leaned forward and fell onto the floor. The DON stated Staff G also did not have Resident #8's soft collar on per his/her care plan, at the time of the fall. The DON stated she wrote Staff G up for failing to use the safety belt and for not following the care plan related to the soft neck collar.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309		

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F 309	Continued From page 15 (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The following deficiency relates to an observation while investigating facility self report 64923-I. Based on resident interview, record review and staff interviews, the facility failed to provide a resident the necessary care and services when the resident was denied a request to be taken to the bathroom. (Residents #10) The facility reported a census of 53 residents. Findings include: According to the Minimum Data Set (MDS) assessment with assessment reference date of 11/16/16, Resident #10 had a Brief Interview for Mental Status (BIMS) score of 11 indicating moderately impaired cognitive abilities. Resident #10 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #10's diagnoses included Non Alzheimer's dementia, malnutrition and depression. In an interview on 1/5/17 at 11:10 a.m. Resident #10 stated just moments earlier he/she had requested to be placed on the toilet for a bowel movement and the aide, Staff O, Certified Nurse Aide (CNA), dismissed his/her request and told the other aide, Staff P, he/she never uses the toilet and placed him/her into his/her wheelchair and propelled him/her into the dining room.	F 309		

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F 309	Continued From page 16 Resident #10 stated he/she was angry and was threatening to hit Staff O, noting they are just lazy. In an interview on 1/5/17 at 11:40 a.m. Staff P, CNA, stated she had entered the room of Resident #10 to assist Staff O with transferring Resident #10 into his/her wheel chair. Based on the conversation it was apparent Resident #10 had requested to use the toilet. Staff O stated Resident #10 never uses the toilet and instead ignored Resident #10's request, transferred him/her into his/her wheel chair and propelled him/her into the dining room. Staff P stated she was an agency staff and not familiar Resident #10's cares so she went along with Staff O. In an interview on 1/5/17 at 11:30 a.m. Staff O, CNA, stated moments ago she and Staff P assisted Resident #10 into his/her wheel chair. Resident #10 was requesting to be placed on the toilet and Staff O stated Resident #10 never uses the bathroom. Staff O stated she told Resident #10 she would put him/her on the toilet after lunch. In an interview on 1/5/17 at 11:57 a.m. the Director of Nursing, stated if a resident requests to use the toilet, the request should be honored. When informed of the incident involving Resident #10 being denied the use of the toilet by Staff O, the DON stated Resident #10 should have been assisted to the toilet.	F 309		
✓ F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -	F 323		

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F 323	Continued From page 17 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: The following deficiency relates to complaint 64711-C. Based on observation, record review and staff interviews, the facility failed to provide adequate supervision to mitigate the risk for accidents for one of eleven residents reviewed (Residents #8); and failed to keep medication carts locked when unattended. The facility reported a census of 53 residents Findings include: According to the Minimum Data Set (MDS) assessment with assessment reference date of	F 323		

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F 323	Continued From page 18 10/19/16, Resident #8 had short and long term memory deficits and severely impaired cognitive abilities. Resident #8 required extensive assistance with transfers, dressing, toilet use and personal hygiene needs. Resident #8's diagnosis included schizophrenia, mild mental retardation and status post C4 neck fracture. Resident #8's plan of care indicated he/she experiences occasional pain related to a C4 neck fracture with approaches which include using a soft collar at all times. Incident/Accident/Unusual Occurrences Form dated 11/22/16 at 7:35 p.m. indicated Resident #8 fell to the floor while taking a shower. Staff G, certified nurse aide (CNA) present in the shower room, stated Resident #8 leaned forward in the shower chair and fell out hitting his/her left side. Left eye brow abrasion, left eye lid purple with swelling and left knee with two abrasions. Staff transferred the resident to the hospital. The Emergency Department physician report dated 11/22/16 identified Resident #8 had a fall from the shower chair and had complained of knee pain and had left eye swelling just prior to arriving. The resident had pain and swelling on the left side of his/her face. The computed tomography (CT) cervical spine scan revealed no cervical spine acute injury. In an interview on 2/13/17 at 10:00 a.m. Staff G, certified nurse aide, stated on the evening of 11/22/16 she was giving Resident #8 a shower. She briefly went around a corner in the shower room to get a towel and as she returned within seconds, Resident #8 was leaning forward in the shower chair and falling out. Staff G attempted to	F 323		

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F 323	Continued From page 19	F 323		

slow the fall, but Resident #8 fell onto his/her face and knees. Staff G stated she used the blue call light to summon help. Staff G admitted she was not using the shower chair seat belt because she was told residents who are capable of sitting upright did not need a seat belt because it would be considered a restraint. Staff G stated she was told this by Staff H, who had trained her, but who no longer worked at the facility. Staff G also stated she had removed Resident #8's soft neck collar during the shower. Staff G stated she believed it was acceptable to remove the collar during a shower and to get it back on once the resident was dried off.

In an interview on 2/13/17 at 11:23 a.m. Staff H, certified nurse aide, stated she had worked at the facility some time ago as a certified nurse aide and while there she was involved with training new certified nurse aides. Staff H stated she could not recall whether she specifically trained Staff G. Staff H stated those she did train were told to always use the shower chair seat belt, regardless of the resident's condition.

In an interview on 1/10/17 at 3:16 p.m. Staff I, certified nurse aide, stated on the evening of 11/22/16 she responded to the shower room blue light and found Resident #8 on the floor. Staff I stated Staff G had not used the shower chair seat belt and the resident slid out and hit her head. Staff I could not recall whether she assisted Staff G with transferring Resident #8 into the shower chair prior to the shower. Staff I stated when giving a shower, she always uses the shower chair safety belt.

In an interview on 1/9/17 at 3:20 p.m. the Director of Nursing (DON), stated on 11/22/16 Resident

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F 323	Continued From page 20	F 323		

#8 fell from the shower chair while being showered. Staff G was giving the shower and had failed to place the shower chair seat belt around the resident. Resident #8 leaned forward and fell onto the floor. The DON stated Staff G also did not have Resident #8's soft collar on per his/her care plan, at the time of the fall. The DON stated she wrote Staff G up for failing to use the safety belt and for not following the care plan related to the soft neck collar. The DON stated there was no formal policy regarding the use of the shower chair seat belt, but it would be her expectation that the belt is always used.

In an interview on 1/9/17 at 2:05 p.m. Staff J, certified nurse aide, stated when giving a resident a shower she always adheres to all safety expectations including the use of the shower chair seat belt.

In an interview on 1/9/17 at 2:34 p.m. Staff K, certified nurse aide, stated she always uses the shower chair seat belt when showering a resident, but noted there was one resident (BR) who was too big to get the seat belt around.

In an interview on 1/9/17 at 4:07 p.m. Staff L, certified nurse aide, stated she always uses the proper number of staff when transferring a resident and always uses the safety belts on the shower chair or whirlpool.

In an interview on 1/9/17 at 4:11 p.m. Staff M, certified nurse aide, stated she always uses the safety belts when giving a resident a shower or whirlpool.

In an interview on 1/9/17 at 4:39 p.m. Staff F, certified nurse aide, stated she always uses the

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F 323	Continued From page 21 safety belts when using the shower chair or whirlpool. 2. During an observation on 1/5/17 at 4:18 p.m. a medication cart assigned to Staff N, Licensed Practical Nurse, was left unlocked and unattended in the hallway, while Staff N was in a resident's room. The medication cart was not in the line of sight of Staff N. During an observation on 1/5/17 at 4:45 p.m. until 4:49 p.m. a medication cart assigned to Staff N, Licensed Practical Nurse, was left unlocked and unattended in the hallway outside the resident's doorway, while Staff N was in a resident's room. Several visitors passed by the medication cart.	F 323		

Preparation and or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and or executed solely because it is required by the provision of federal and/or state law.
This is my credible allegation of compliance that F223, F224, F282, and F323 was corrected on 23rd of February, 2017, and F309 was corrected on 24th of February 2017.
F223 It continues to be the policy of Oakwood Specialty Care that residents be free from abuse/involuntary seclusion.
Resident# 9 no longer resides at the facility as of 1/9/17.
Resident #10 and #11 and all other residents are and will be free from abuse.
Staff was reeducated regarding the facility abuse policy, reporting abuse, and what to do if they witness inappropriate touching or fondling. The facility will continue to educate all employees at the time of hire, annually, and the two hour mandatory training every 5 years to ensure employees are knowledgeable on the abuse policies and procedures
Monitoring to ensure staff have been educated as required per Dependent Adult Abuse guidelines will be a part of the facility's QA process.

F224 It continues to be the policy of Oakwood Specialty Care that residents be free from mistreatment/neglect/ misappropriation.
Resident# 9 no longer resides at the facility as of 1/9/17.
As a facility we will,

1. Evaluate the risk the resident presents to determine the level of supervision needed to monitor the resident.

2. Determine resident's risk for abusing other residents and ensure adequate interventions are in place.

3. Identify the problem on the care plan with intervention to provide adequate supervision of the individual.

4. Ensure all staff are knowledgeable of the resident's behaviors and the interventions and monitoring expectations for that resident.

On 1/19/17 staff was reeducated regarding the facility abuse policy, reporting abuse, and what to do if they witness inappropriate touching or fondling.
Monitoring will be a part of the facility's QA process

F282: It continues to be the policy of Oakwood Specialty Care to provide patient services per a care plan.
Staff will provide care according the resident's personalized care plan for resident #8, as well as for all residents of the facility.
Staff have been re-educated on the importance of following the care plan and care cards on 1.9.17.
Monitoring for compliance will be a part of the facility's QA process
F309: It continues to be the policy of Oakwood Specialty Care to provide care and services for the highest well-being.
If resident #10, or any other resident requests to be taken to the bathroom, this care will be provided to them at the time of the request.
Staff who were caring for the resident at the time of this incident, on 1/5/17, were immediately verbally educated that residents must toileted when they request to be toileted.
All nursing staff were reeducated about the importance of toileting residents at the time of request on 2/24/17.
Monitoring for compliance will be a part of the facility's QA process.
F323: It continues to be the policy of Oakwood Specialty Care that all residents environment be free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.
Resident # 8, as well as all other residents will be provided safety during a shower by continued use of safety belts on shower chairs.

All nursing staff were immediately educated regarding the importance of using the seat belt when giving showers on 1/9/17. Shower chairs were inspected to ensure that there is a chair with appropriate size seat belt for all residents.
Facility has added the use of the seat belt safety devices to the orientation process for new staff.
Nurses/CMAs were provided with verbal re-education related to keeping medication carts locked on 1/5/17, and med pass audits were initiated to include observations of appropriately securing medication carts. Monitoring continues with quarterly audits, and QA observations.
This will continued to be monitored through the facility's QA process.

Thank you,
Rachel Gooden
Administrator
Oakwood Specialty Care