Citation Numb	er: #8064				Date: Ju	ly 22, 2020
Facility Name: Oakwood Specialty Care Facility Address/City/State/Zip: 200 16 <sup>th</sup> Ave East Albia, IA 52531		JS MW	Survey Dates: July 7 – 8, 2020			020
Rule or Code Section	Natur	e of Violation	Class Fine Amount			Correction date
58.19(2)j	residents. The resident shall provide, as approp nursing services under qualified nurses with an these rules: 58.19(2) Medication and j. Provision of accurate intervention for all resid adverse symptoms whice mental, emotional, or pl DESCRIPTION: Based on record review failed to promptly assess intervention for 1 of 4 sa severe pain. On 7/2/20 repeatedly reported Resident #1. The N 9:45 p.m. and even their reported by a Nurse Aid Resident #1 passed aw	<b>19(2)</b> Medication and treatment. rovision of accurate assessment and timely ervention for all residents who have an onset of verse symptoms which represent a change in ntal, emotional, or physical condition. (I, II, III) <b>SCRIPTION:</b> sed on record review and staff interviews, the facility ed to promptly assess and provide timely ervention for 1 of 4 sampled (Resident #1) who had vere pain. On 7/2/20 at 8:00 p.m., A Nurse Aide eatedly reported Resident #1 had abdominal pain. a Nurse Aide repeatedly requested the Nurse check Resident #1. The Nurse assessed Resident #1 at 5 p.m. and even then minimized the symptoms orted by a Nurse Aide and another Nurse. sident #1 passed away less than two hours later. e facility reported a census of 33.		(He	000 Id in ension)	Upon Receipt

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Resident #1's diagnosis included coronary artery   disease, hypertension, gastroesophageal reflux   disease, diabetes mellitus, cerebral vascular accident,   seizure disorder and chronic obstructive pulmonary   disease. Resident #1 had also been confirmed   positive for COVID-19 recovered.   During an interview on 7/7/20 at 2:11 p.m. Staff A   (Nurse Aide) stated on the evening of 7/2/20 she was   working a 2:00 p.m. to 10:00 p.m. shift and assigned to   Resident #1's hall. Sometime shortly after supper,   Resident #1 was laid down and Staff C passed his   evening medications. At 8:00 p.m., Resident #1   activated his call light and Staff A responded.   Resident #1 stated he was having severe abdominal   pain and refused to allow Staff A to touch his   abdomen. Staff A stated Staff C di not   check on Resident #1 at that time. At 8:20 p.m.,   Resident #1 again activated his call light and Staff A   responded. Resident #1 was complaining of intense   abdominal pain. Staff A stated she again told Staff C   of Resident #1's complaint. Staff C responded, stating   Resident #1 do not have anything (medication) for his
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stomach and she didn't think she needed to assess	
him. At 8:45 p.m. Resident #1 activated his call light	
and Staff A responded. Resident #1 stated he was still	
having severe abdominal pain. Staff A stated she	
again informed Staff C who made no comment and did	
not check on Resident #1. Between 9:00 p.m. and	
9:10 p.m. Staff A was doing rounds and entered	
Resident #1's room. Resident #1 was still complaining	
of severe pain, to the point of crying in pain. Staff A	
again informed Staff C who did nothing at that time. At	
9:30 p.m. Staff A was at the nurse's station and shortly	
later Staff C came up and stated Resident #1's	
abdomen was not distended and his bowel sounds	
were okay. Staff A stated she and Staff B (Licensed	
Practical Nurse) entered Resident #1's room.	
Resident #1 stated he was still having severe pain and	
when asked, stated Staff C had not been in his room.	
Both Staff A and Staff B returned to the nurse's station.	
Staff B stated she was not seeing the same thing	
which Staff C was reporting and suggested Staff C	
return to Resident #1's room or Staff B would do the	
assessment. Staff C then insisted she had assessed	
him. Staff A stated Resident #1 said he wasn't	
checked on and so is Resident #1 lying. Staff A stated	
she told Staff C Resident #1 was requesting to go to	
the hospital and Staff C responded, stating he couldn't	
go to the hospital because he is on hospice. Staff A	
stated that is not true. Shortly after that (9:45 p.m.),	
Staff C finally went to Resident #1's room and	
assessed him. Staff C came back to the nurse's station	
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	and called hospice. St	aff A stated she was scheduled				
		out left the facility to go home				
	for a bit, planning on returning a little later. While out of the facility Staff A received the call informing her					
	Resident #1 had passed	d away.				
	During an interview on	7/7/20 at 4:11 p.m., Staff B				
	(Licensed Practical Nurse) stated on 7/2/20 she was					
		rom 2:00 p.m. until 6:00 a.m.				
		B stated that evening Staff A				
		ed her expressing frustration				
		ated she has repeatedly told I was complaining of stomach				
		said something to Staff C, who				
	responded, stating Res					
		mach and he has had a recent				
		B stated after her break at				
		A remained frustrated and Staff				
		that maybe she should assess				
		abdomen is distended, check out exactly where the pain is in				
		kind of pain he is feeling. Staff				
		aff C reluctantly walked down				
	the hall as Staff B and S	Staff A remained at the nurse's				
		nor Staff A witnessed Staff C				
		vas in isolation) or enter				
		hen Staff C returned to the				
		asked how Resident #1 was esident #1's abdomen was not				
		el sounds were normal and he				

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seemed to be more comfortable. Staff B stated, she and Staff A then went down to Resident #1's room. Staff B stated Resident #1's abdomen was visibly distended and painful to the touch. It was obvious that Resident #1 was visibly experiencing severe pain. Resident #1 stated he felt like he needed to vomit.
Staff B stated Resident #1's abdomen was visibly distended and painful to the touch. It was obvious that Resident #1 was visibly experiencing severe pain.
distended and painful to the touch. It was obvious that Resident #1 was visibly experiencing severe pain.
Resident #1 was visibly experiencing severe pain.
Regident #1 stated he falt like he needed to versit
Staff B and Staff A attempted to reposition him for
comfort. The staff asked Resident #1 if Staff C had
entered his room and checked on him. Resident #1
stated she had not. Staff B and Staff A then returned
to the nurse's station and reported Resident #1's
condition to Staff C. Staff C insisted she had assessed
Resident #1. Staff A then confronted Staff C stating
Resident #1 was not assessed and that he was
requesting to go to the hospital. Staff B stated she
also didn't believe Staff C had went in his room
because Staff C described the abdomen as soft and
bowel sounds normal and her findings were totally
different. Staff C didn't provide an answer. Staff C
stated I don't know what you want me to do. Staff C
told Staff A, Resident #1 was on hospice so he could
not go to the hospital. Staff B suggested Staff C
contact hospice, which she did and hospice agreed to
come in. Staff B stated later on about 10:30 p.m. Staff
D came to her stating Resident #1 was vomiting
profusely and she needed help. Staff B stated she and
Staff D attempted to reposition Resident #1 and she
applied his oxygen. Resident #1 lungs were rattling
and he was complaining of not being able to breathe.

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	Staff B stated within minutes Resident #1 passed away.					
	During an interview on 7/8/20 at 2:36 p.m. Staff C (Licensed Practical Nurse) stated she usually starts her evening medication pass between 6:30 p.m. and 7:00 p.m. On the evening of 7/2/20, Staff C stated she remembers passing Resident #1's evening medications around that time. Resident #1 had mentioned that his stomach was bothering him and he thought he may have eaten his potatoes too fast. Sometime between 8:00 p.m. and 9:00 p.m. Staff A had told her Resident #1 was wanting something for his stomach. Staff C stated Resident #1 does not have anything ordered for an upset stomach. Staff C stated she admits she should have went and checked on Resident #1, but noted she was busy. At 9:00 p.m., Staff A reported Resident #1's abdomen was hard and distended and he was in pain. Staff C stated she went and assessed Resident #1 at around 9:30 p.m. and his abdomen was soft, bowel sounds good and no					

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If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

complaints of pain. Staff C stated Resident #1 asked about going to the hospital and she stated she would need to call hospice which Resident #1 was okay with. Staff A was upset and Staff C stated if you want him to go, I'll send him. Staff A stated you won't because you don't want to do the paper work. Staff C stated she called hospice and they said they will come out and see him. Staff C stated she doesn't recall discussing Resident #1's condition with Staff B that evening.

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According to Progress Notes dated 7/2/20, at 9:45 p.m., Staff C documented Resident #1's skin warm and dry, color pale, no cough noted, lungs clear bilaterally, respirations even and unlabored, no complaints of dyspnea, abdomen distended, soft and not tender to touch, bowel sounds all quadrants, resident voiding ok, vital signs Temperature: 98.5, Pulse: 72, Respirations: 16, Blood Pressure: 115/68, Blood Oxygen Saturation : 94% on room air. Resident #1 wanted hospice called. Power of Attorney present and aware. According to Progress Notes dated 7/2/20, at 10:17 p.m. Staff C notified hospice and hospice returned call at 10:32 p.m. and will planned on visiting Resident #1.		
During an interview on 7/8/20 at 9:33 a.m. Staff F stated she was contacted by the facility nurse (Staff C) on the evening of 7/2/20. Staff C indicated Resident #1 was complaining of abdominal pain and his abdomen was slightly distended. Resident #1 had good bowel sounds and had a bowel movement within the last 24 hours. Staff C stated Resident #1 had been asking about gong to the hospital and she told him he was on hospice and didn't need to go. Staff C stated Resident #1 then requested to see the Hospice Nurse. During an interview on 7/7/20 at 3:35 p.m., Staff E (Nurse Aide) stated she was working the evening shift on 7/2/20 and assigned Hall 1. Staff E stated she		Page <b>7</b> of <b>1</b>

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recalled Staff A being frustrated with Staff C for not checking on Resident #1. Staff A stated Resident #1 complained of stomach pain and she told Staff C several times. Staff E stated she recalled witnessing Staff A informing Staff C of Resident #1's stomach pain and Staff C stated she would get to it later. Staff E reported working at the facility for 6 weeks and noticed Staff C reacted slowly to concerns. During an interview on 7/8/20 at 10:12 a.m., the Medical Director stated he was not familiar with Resident #1. The Medical Director received a call from Hospice on the evening of 7/2/20 to inform him Resident #1 passed away. The Medical Director was briefed on Resident #1's condition prior to death, noting Resident #1 had abdominal pain, distention, and emesis over a three hour period and then suddenly died. The Medical Director stated based on that information, it was likely something new like a ruptured abdominal aneurysm or intra-abdominal bleed. The Medical Director stated there may have		
bleed. The Medical Director stated there may have been some aspiration related to the vomiting, but that would not account for the abdomen distention and pain. The Medical Director stated given the brief onset of symptoms to sudden death, it was unlikely earlier medical interventions would have changed anything.		

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