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 07/08/2020

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: 7/9/20 The following deficiency relates to investigation of complaint #91824 conducted July 7 - 8, 2020. Complaint #91824-C was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to promptly assess and provide timely intervention for 1 of 4 sampled (Resident #1) who had severe pain. The staff repeatedly reported the pain to the charge nurse and the charge nurse failed to intervene in a timely manner. The facility reported a census of 33. Findings include: According to the Minimum Data Set (MDS) assessment dated of 6/11/20, Resident #1 had a Brief Interview for Mental Status score of 6 indicating a moderately impaired cognitive status.	F 684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Gaarden MHS MHA	Administrator	7/23/20 07/22/2020

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.

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 07/08/2020

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 684	Continued From page 1 Resident #1 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. 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 she reported Resident #1's complaint to Staff C. Staff A stated Staff C did 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 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	F 684		

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 07/08/2020

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 684	Continued From page 2	F 684		

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 and called hospice. Staff A stated she was scheduled to work a double shift, but 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 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 working a double shift from 2:00 p.m. until 6:00 a.m. the following day. Staff B stated that evening Staff A (Nurse Aide) approached her expressing frustration with Staff C. Staff B stated she has repeatedly told Staff C that Resident #1 was complaining of stomach pain. Staff B stated she said something to Staff C, who responded, stating Resident #1 has nothing (medication) for

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 07/08/2020

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 684	Continued From page 3	F 684		

his stomach and he has had a recent bowel movement. Staff B stated after her break at around 8:45 p.m. Staff A remained frustrated and Staff B suggested to Staff C that maybe she should assess Resident #1. See if his abdomen is distended, check bowel sounds and find out exactly where the pain is in his abdomen and what kind of pain he is feeling. Staff C stated she would. Staff C reluctantly walked down the hall as Staff B and Staff A remained at the nurse's station. Neither Staff B nor Staff A witnessed Staff C gown up (Resident #1 was in isolation) or enter Resident #1's room. When Staff C returned to the nurse's station, Staff B asked how Resident #1 was doing. Staff C stated Resident #1's abdomen was not distended, soft, his bowel sounds were normal and he 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 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

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 07/08/2020

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 684	Continued From page 4	F 684		

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. 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 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

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 07/08/2020

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 684	Continued From page 5 they will come out and see him. Staff C stated she doesn't recall discussing Resident #1's condition with Staff B that evening. 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 recalled Staff A being frustrated with Staff C for not checking on Resident #1. Staff A	F 684		

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 07/08/2020

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 684	Continued From page 6 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 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.	F 684		

Preparation and/or submission of the Plan of Correction is not a legal admission that the violations existed or exist or that the deficiencies herein are correctly cited, and it is not to be construed as an admission against the interests of Oakwood Specialty Care or its affiliates, employees, agents, or individuals who drafted/submitted or may be discussed in this Plan of Correction. Rather, submission of this Plan of Correction is to respond to the specific matters addressed in the Statement of Deficiencies related to the alleged deficiencies and demonstrate how the facility's programs, policies, and practices promote its commitment to assure that all residents receive services that are of quality that meet professionally recognized standards of care and that comply with all requirements for licensure and participation.

Credible allegation of compliance date: July 9th, 2020

F684

Oakwood ensures that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and residents' choices. Quality of care is a fundamental principle that applies to all treatment and care provided to all Oakwood residents.

Resident #1 no longer resides in the facility

Staff C is no longer employed in the facility.

On 7/9/2020

Staff was educated to alert the charge nurse of any condition change to the charge nurse promptly. If staff are not satisfied with how the charge nurse assesses the resident; they are encouraged to call the Director of Nursing or the Administrator to follow up on the situation.

Licensed nursing staff was educated upon notification of condition change that they need to go assess the resident promptly and notify family and/or physician as needed, followed by, documentation in PCC.

Residents with condition changes will then be added to hot charting on the clinical communication board in PCC and condition changes will be reported to the oncoming shift nurse at shift change.

The facility's DON or Designee will audit hot charts as part of the facility's QA process for appropriate assessment and intervention, along with proper Dr./Family notification and initiation of any new orders. Problems will be corrected at the time of audit

Quality Assurance Monitoring of Hot Charting is performed by the Director of Nursing or designee and will be discussed with QA team. Problems will be corrected as they are observed.