Department of Inspections and Appeals
Health Facilities Division
Citation

Number: #5535				**Report Date:** January 20, 2022
Facility Name: Oakwood Specialty Care Center			**Survey Dates:** December 13 – 30, 2021	
Facility Address: 200 16th Ave East	**JS**			
City: Albia				

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
58.43(135C)	481—58.43(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury. Each resident shall be free from chemical and physical restraints except as follows: when authorized in writing by a physician for a specified period of time; when necessary in an emergency to protect the resident from injury to the resident or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician; and in the case of an intellectually disabled individual when ordered in writing by a physician and authorized by a designated qualified intellectual disabilities professional for use during behavior modification sessions. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II)	**I**	**$7,250 (Held in Suspension)**	**Upon Receipt**
58.43(9)	58.43(9) Allegations of dependent adult abuse. Allegations of dependent adult abuse shall be reported and investigated pursuant to Iowa Code chapter 235E and 481—Chapter 52. (I, II, III)			
235E.2 10	235E.2 Dependent adult abuse reports in facilities and programs			

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	10. The department shall adopt rules which require facilities and programs to separate an alleged dependent adult abuser from a victim following an allegation of perpetration of dependent adult abuse and prior to the completion of an investigation of the allegation. Independent of the department's investigation, the facility or program employing the alleged dependent adult abuser shall conduct an investigation of the alleged dependent adult abuse and 2011 Iowa Code CD-ROM 6 determine what, if any, employment action should be taken including but not limited to placing the alleged dependent adult abuser on administrative leave or reassigning or terminating the alleged dependent adult abuser as a result of the investigation by the facility or program. If the facility or program terminates the alleged dependent adult abuser as a result of the investigation by the facility or program or the alleged dependent adult abuser resigns, the alleged dependent adult abuser shall disclose such termination or investigation to any prospective facility or program employer. An alleged dependent adult abuser who fails to disclose such termination or investigation is guilty of a simple misdemeanor. DESCRIPTION: Based on clinical record review, observations, staff interviews, and facility abuse policy review, the facility failed ensure the resident's right to be free from abuse on two occasions, failed to notify the State Agency			

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	within 24 hours of the allegation of abuse, failed to separate the resident from the alleged perpetrator, and failed to conduct two timely abuse investigations for 1 of 3 sampled (Resident #9) for abuse. The facility reported a census of 45 residents. Findings included: 1. Free From Abuse The Minimum Data Set assessment dated 9/22/21, for Resident #9, revealed a BIMS score of 6, which indicated the resident's cognition severely impaired. The MDS revealed Resident #9's diagnoses included anxiety, depression, schizophrenia, and anoxic brain injury. The MDS revealed the resident experienced behaviors not directed towards others. The Care Plan revealed Resident #9 has major depressive disorder, generalized anxiety disorder, and a mood disorder and prescribed medications to treat those disorders. The Care Plan revealed the resident has impaired cognitive function and difficulty expressing her ideas or wants due to a traumatic brain injury and anxiety. Staff should allow resident plenty of time to respond. The Care Plan revealed the resident also has a history of behaviors and hit her previous roommate. The resident sometimes displays crying, pacing, yelling for her friend when her anxiety is worsening. The Care Plan revealed when the resident has increased anxiety			

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	staff can assist the resident by having her talk to her friend. An observation on 12/13/21 at 2:20 pm revealed the Resident #9 ambulating out of her room, crying and wailing. The resident followed the staff around while crying. Staff attempted to redirect the resident and console her. An observation on 12/21/21 at 10:23 am revealed Resident #9 by the nurse's station. Resident wailing in a repetitive speech. Staff tried to console the resident. A Progress Note dated 10/29/21 at 11:20 am, revealed the resident room changed due to behaviors and increased crying. Resident under one-on-one observation. A Progress Note dated 10/29/21 at 3:58 pm, revealed the social worker with the resident for one on one observations. A Progress Note dated 10/29/21 at 4:41 pm, revealed Social Worker reported to Staff B, Registered Nurse (RN) to continue with 15 minutes checks on Resident #9. A Progress Note dated 10/29/21 at 9:33 pm, revealed Resident #9 had behaviors earlier in the shift and on one on one observations. A Progress Note dated 11/10/21 at 9:59 pm, showed Resident #9 had behaviors of crying and yelling during the shift.			

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	An undated Investigative Report revealed on 11/23/21 the Social Worker reported on 10/29/21 while performing one-on-one observations for Resident #9, the resident became upset while sitting in the dining room and the Social Worker assisted the resident to her room. The report showed the resident began crying and staff B, RN came down the hall and administered medications to Resident #9. Resident #9 did not calm down and stood in the doorway refusing to enter her room. The Social Worker reported she attempted to coax the resident into her room but Staff B used her hand to put the resident in her room and held her in the room while she shut the door. An undated written statement from Social Worker, revealed on 10/29/21 around 4 pm, Staff B, RN took Resident #9 into her room and shut the door. The report from the Social Worker revealed the resident started screaming and saying "no". The Social Worker reported the resident not combative at the time of the incident. A monthly schedule for October 2021 revealed Staff B, RN worked on 10/29/21 for a 2 pm to 10 pm shift. In an interview on 12/21/21 at 3:30 pm, the Regional Consultant reported during her investigation, the Social Worker reported to her Staff B, RN closed the door shut to Resident #9's room. The Regional Consultant reported the way the Social Worker explained it to her			

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	is the Social Worker felt Staff B was aggressive but no harm came to the resident. In an interview on 12/27/21 at 10:32 am the Social Worker, recalled on 10/29/21 being in Resident #9's room because the resident required one-on-one observation. The Social Worker reported the resident standing in the doorway crying when Staff B RN, approached the resident, put her hand on the resident's abdomen as to move her, and then shut the resident's door. The Social Worker reported Staff B did not hold the door closed. The Social Worker reported she stayed in the room with the resident, talked to her, calmed her down and then reopened the door for the resident. In an interview on 12/28/21 at 1:13 pm, Staff B, RN, reported she could not specifically remember the incident with Resident #9 regarding shutting the door. She reported many of the residents complained about Resident #9 being loud so she would shut Resident #9's door to appease the other residents. She reported the resident often-received one-on-one observation due to her behaviors so she could not recall one single event. She reported if the resident ever cried loudly and if she ever stood in the way of the doorway, she would make sure the resident cleared the area before she would shut the door to Resident #9's room. She reported she did not assault the resident or hold the resident in her room.			

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	An undated Investigative Report revealed further investigation of an allegation of confinement reported on 11/23/21. Staff F, Certified Nurse Aide (CNA) reported she saw Staff D, CNA hold Resident #9's door shut as instructed by Staff B, RN. Staff F unable to recall the date this occurred. An email from Staff B, RN, dated 11/30/21 time stamped at 8:14 am, Staff B reported on 11/10/21 she walked Resident #9 down the hallway with the resident toward Resident #9's room. Resident #9 began to escalate behaviors of crying and screaming. Staff B reported once at Resident #9's room, Resident #9 started screaming, "Where's Billy?" Staff B reported she used distractions, offered Resident #9 a snack, asking the resident to calm down, and asking if she wanted to use the restroom or to watch television. The e-mail revealed the resident screamed "no, no, no," and flailed her arms out. Staff B's email revealed she thought Resident #9 failed to hit Staff B. Staff B reported the resident screamed and became aggressive and no staff were around to help. Staff B reported she shut the door between her and Resident #9 but did not hold the door shut to the resident's room. Staff B wrote she tried to protect herself and the resident by keeping a door between them. In the email, Staff B wrote she asked the resident to back away from the door and helped her.			

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	A schedule for November 2021 revealed Staff B, RN and Staff D, CNA scheduled to work 2 pm to 10 pm shift on 11/10/21. A Daily Assignment sheet revealed Staff B, RN and Staff D, CNA worked the evening shift on 11/10/21. In an interview on 12/27/21 at 9:23 am, Staff D, CNA reported around suppertime on 11/10/21, Resident #9 was emotional. Staff D witnessed Staff G, CNA place Resident #9 in her room and held the door so Resident #9 could not get out. The nurse down the hall took over and held the door shut for about 10 minutes. Staff D reported the nurse stopped her and told her to hold the door so the nurse could pass medications. Staff D reported she held the door for about two minutes but then asked another staff member who had come in early for her shift to assist the resident. Staff D reported she felt what Staff G and the nurse did to the resident is wrong. In an interview on 12/27/21 at 10:16 am, Staff F, CNA reported she worked night shift but came in to work at 6 pm to clean. She recalled she came out of a room and witnessed Staff D, CNA, standing outside Resident's #9 door. Staff F reported Staff D did not appear to hold the door shut. Staff F reported Staff D asked her to help because she would need to be getting the residents to bed soon. Staff F reported she went in and assisted the resident to the restroom, and then went back to			

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	cleaning. Staff F reported she recalled the resident crying. However, Staff F reported the resident cried often and not an unusual event. In an interview on 12/28/21 at 1:13 pm, Staff B, RN, could not recall the event very well, she reported the resident had a history of behaviors. Staff B reported Resident #9 would sometimes become over-stimulated and begin to cry and have behaviors. Staff often would then take Resident #9 from the overly stimulated environments and assisted Resident #9 to her room to calm her down. Staff B recalled Resident #9 in her room crying and inconsolable. Staff B reported Resident #9's behaviors did not improve and only escalated. Staff B reported she closed the door between her and the resident and talked to her through the door. She reported when the resident started to calm down, she cracked the door open, talked to her through it, and told her when she had calmed down she could come out. Staff B reported she returned to her med cart and Resident #9 came out to the cart and seemed fine. Staff B reported she did not ask any other staff to hold the door shut for her so she could pass medications. In an interview at 12/28/21 at 12:16 pm, the previous Administrator reported when Resident #9 escalated in behaviors and over-stimulated, staff would try to remove the resident from the stimulated environment, as an intervention, and take her to her room but the process did not include holding the door shut.			

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	A Resident Abuse under Federal Certification Guidelines policy dated November 2019 revealed each resident has the right to be from abuse and involuntary seclusion. The interpretive guidelines revealed abuse is defined as a willful infliction of unreasonable confinement, intimidation or punishment resulting in pain or mental anguish. 2. Reporting In an interview on 12/21/21 at 3:30 pm, the Regional Consultant reported only being made aware of these events in late November. The Regional Consultant reported in an investigation, the Social Worker reported sending an e-mail to the previous Administrator. During the investigation with the previous Administrator, she reported to the Regional Consultant she did not receive an email. The Regional Consultant stated if there is an allegation of abuse, the Social Worker should have talked to someone before leaving the facility and leaving the resident in Staff B's care. In an interview on 12/28/21 at 11:45 am, Staff H, CNA, reported her and Staff I, CNA, received a report, on the following morning of the event, from Staff F, CNA who witnessed the event. Staff H and Staff I brought it up in the 9 am daily morning meeting with the nursing staff, and were told to write statements from the administrator (previous administrator). Staff H			

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	reported she gave her written report to Staff J, previous administrator. She reported she believed Staff I gave her written report to Staff J, previous interim DON. Staff H reported there were other occurrences with Staff B doing unethical things previously to this event. Staff H reported when she asked the Staff J why Staff B still allowed to work, she reported Staff J said, "I wish we weren't so desperate for help." In an interview on 12/28/21 at 12:16 pm, Staff K, previous Administrator, reported never being told about Resident #9 being confined to her room on either account. She reported her expectations of staff are for them to report directly to their supervisors for suspected abuse. She stated if the possible perpetrator is the direct supervisor then staff should have called her directly. She reported once an allegation of abuse has been made, they would start an investigation and notify the Department of Inspections and Appeals (DIA). A Timely Abuse Reporting policy dated 11/2019 revealed staff should report all allegations of abuse, neglect, exploitation, and mistreatment, to the charge nurse immediately. The charge nurse is responsible for immediately reporting the allegations of abuse to the administrator. All allegations of resident abuse should be reported to DIA no later than two hours after the allegation is made.			

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	In an interview on 12/30/21 at 8:59 am, Staff J, MDS Coordinator, reported if staff suspect abuse they should tell management immediately. If management is not is not available, they should report to their charge nurse. If the alleged perpetrator is one of the charge nurses then staff should inform the other charge nurse on duty. Once management is made aware of the abuse allegation, they should reported it to DIA within 2 hours. 3. Separate/Investigate An undated Written Statement from Social Worker, revealed on 10/29/21 around 4 pm, Staff B, RN took Resident #9 into her room and shut the door. The report from the Social Worker revealed the resident started screaming and saying "no". The Social Worker reported the resident not combative at the time of the incident. A copy of a printed email dated 10/29/21 at 5:01 pm revealed a Social Worker sent an e-mail to the previous administrator and the MDS coordinator to inform them of the event she witnessed. A monthly schedule between 10/29/21 - 11/30/21 revealed Staff B worked the following dates in the facility: 10/29/21 through 11/5/21, 11/7/21, and 11/9/21 through 11/19/21.			

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	Time punches for Staff B, RN revealed she worked the following days 10/29, 10/30, 10/31, 11/2, 11/3, 11/4, 11/5, 11/7, 11/9, 11/10, 11/11, 11/12, 11/13, 11/14, 11/16, 11/17, 11/18, 11/19, and 11/22. A monthly schedule between 11/10/21 - 11/30/21 revealed Staff D, CNA worked the following dates in the facility: 11/10/21. Time punches for Staff D, Certified Nurse Aide (CNA) revealed she worked 11/10/21 from 2 pm till 6 pm. In an interview on 12/27/21 at 10:32 am, the Social Worker reported she e-mailed the administrator and Staff J, MDS Coordinator, to inform them of what she witnessed. The Social Worker reported she never heard back from either of them and Staff B continued to work at the facility with Resident #9. The social worker stated "I guess it is my fault. If I had a conversation with them then maybe this wouldn't have happened." In an interview on 12/21/21 at 3:30 pm, the Regional Consultant reported the current management team not made aware of the events which took place with Resident #9 and Staff B until late November. The Regional Consultant reported she interviewed Staff K, previous Administrator, who reported not knowing of the events or receiving an email from the social worker.			

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	In an interview on 12/27/21 at 9:45 am, Staff E, Certified Medication Aide (CMA), reported at a 9 am morning meeting Staff H, CNA and Staff I, CNA brought it to their attention that Staff B, RN had a CNA hold Resident #9's door closed. Staff K, the previous Administrator, had Staff H and Staff I write a written statement. Staff E reported Staff K said in the meeting stated, "its just said we are this short that we gotta keep people." In an interview on 12/28/21 at 1:13 pm, Staff B, RN reported no one had talked to her previously or investigated anything as far as she knows. Staff B said on 11/22/21, the current Director of Nursing (DON) of the facility told her she could not return to the facility to work due to being under investigation. Staff B reported when Resident #9 acted out and she closed the door on the resident, if someone had seen her, she felt the staff who witnessed the event should have come down and offered to help her instead of just doing nothing and report her. In an interview on 12/28/21 at 11:44 am, Staff H, CNA, reported her and Staff I, CNA received a morning report from Staff F, CNA. Staff H reported in report, Staff F reported seeing a CNA hold a door shut to Resident #9's room. Staff H reported her and Staff I brought up what they heard in the 9 am morning meeting with the nursing staff. Staff H reported to Staff K, the previous Administrator told her and Staff I to give a written			

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	statement of what they heard. Staff H wrote a statement and gave it to Staff K. Staff H reported Staff B, RN, had done unethical things prior to this event and management fully aware, but asked why Staff B allowed to work. Staff H reported Staff K stated "I wish we weren't so desperate for help." In an interview on 12/29/21 at 8:14 am, Staff I, CNA, reported she received a shift report from Staff F, CNA in the morning around 5:45 am. Staff I stated Staff F told her and Staff H, CNA on the evening shift, Staff F witnessed a CNA hold a door shut to Resident #9's room. She stated in the report, CNA said Staff B, RN told CNA to hold the door shut. Staff I reported unsure whether Staff F reported what she saw to anyone. Staff I reported she brought it up in the 9 am nurses meeting and told Staff K, previous Administrator what she received in report. Staff I reported Staff K told her and Staff H to write a statement. Staff I reported she wrote her statement and certain she gave it to Staff K. Staff I said if someone witnesses a staff member being mean to a resident, staff should separate and make sure the resident is safe. Then report to your supervisor, and if they don't do anything about it then call in the allegation yourself. In an interview on 12/28/21 at 12:16 pm, Staff K, previous Administrator, reported never being told about Resident #9 being confined to her room on either account. Staff K reported often Staff H would gossip			

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	about things which were hearsay. Staff K reported she would ask Staff H and other staff to give written statements anytime they had something to tell. Staff K reported she never received written statements regarding Resident #9 being confined. She reported her expectations of staff are for them to report directly to their supervisors any suspected abuse. She stated if the possible perpetrator is the direct supervisor then staff should have called her directly. She reported once an allegation of abuse has been made, they would start an investigation and notify the State Agency. FACILITY RESPONSE:			

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