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 01/31/2023

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 ✓ ok/CP	INITIAL COMMENTS Correction Date 2-20-23 . An On-Site Revisit of the survey ending October 27, 2022 and investigation of Complaints # 108473-C, #109284-C, #109446-C, #109887-C, #110160-C and Facility Self-Reported Incident #110289-I was conducted January 23, 2023 to January 31, 2023. The results for the Facility Self-Reported incident #110480-M will be sent to the facility at a later date under a separate cover. All deficiencies were corrected for the revisit, but additional deficiencies were cited from the complaint investigation. Complaints # 109446-C, #109887-C, and #110160-C were substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000		2/20/23
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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 medical symptoms. §483.12(a) The facility must-	F 600	**Description:** F600 Free From Abuse and Neglect **Plan of Correction:** Staff will be educated on the definition of abuse and neglect. Education provided to staff regarding reporting alleged violations. **How residents affected & residents with potential of being affected were identified:** Residents that reside to Oakwood Specialty Care have the potential to be affected	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Tony Janusz — LNHA

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F 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, policy review, staff interview, and resident interview, the the facility failed to ensure 1 of 4 residents was free from abuse(Resident #4). The facility reported a census of 36 residents. Findings Include: 1. The Quarterly Minimum Data Set (MDS) assessment tool, dated 12/30/22, listed diagnoses for Resident #4 which included diabetes, pain in the right knee, and chronic pain syndrome. The MDS stated the resident required extensive assistance of 1 staff for personal hygiene, extensive assistance of 2 staff for bed mobility, transfers, dressing, and toilet use, and depended completely on 1 staff for bathing. The MDS listed the resident's BIMS(Brief Interview for Mental Status) score as 12 out of 15, which indicated moderately intact cognition. A Care Plan entry, dated 5/5/22, stated the resident utilized a Hoyer lift (a type of mechanical lift) with the assistance of 2 staff for transfers. Staff I's Employee Punch Report for January 2023 documented she worked 6:30 a.m. -12:00 p.m. on 1/9/23. The undated, untitled facility investigation stated the resident reported that staff dropped her in the	F 600	**Corrective action taken for resident(s) affected:** Staff member terminated. **Measures or systemic changes made to ensure this will not recur and affect others:** Staff will be educated on the definition of abuse and neglect. Education provided to staff regarding reporting alleged violations.An Easy Way lift Operator's manual with instructions on proper use of the Emergency Release button has been attached to the lifts for easy reference. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** 4 Audits per week of staff knowledge regarding abuse and neglect will be conducted on staff for 4 weeks. Then 2 Audits per week of staff knowledge regarding abuse and neglect will be conducted on staff for 2 additional weeks. 2 Audits per week of staff conducting transfers with a Hoyer Lift for 4 weeks. Then 1 Audit per week for an additional week. Results of audits will be submitted to QAPI for further review.	

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F 600	Continued From page 2	F 600		

Hoyer by pulling the emergency release and one staff laughed.

During an interview on 1/24/23 at 9:03 a.m., Resident #4 stated 2 Certified Nursing Assistants(CNAs) had her up in the Hoyer lift and one of the aides pulled the emergency release and she landed in the recliner and it hurt her. During the interview, Resident #4's husband was present(Resident #5). Resident #5 stated that he observed this event and after it happened the aide threatened to do it again during subsequent transfers and placed her hand on the emergency release. Resident #5 stated that the aide thought it was funny.

During an observation on 1/24/23 at 9:43 a.m., Staff L interim Director of Nursing(DON) and Staff K CNA transferred Resident #4 from her electric wheelchair into her bed using the EZ Lift(a type of mechanical lift). Staff F CNA then arrived and assisted with personal cares and then Staff K and Staff F transferred the resident back to the electric wheelchair using the lift.

During an interview immediately after cares on 1/24/23 at 10:12 a.m., Staff F stated that the emergency release was located at the bottom of the center bar of the lift and in order to utilize it, one would pull it up. She stated when pulled, the resident would descend and it depended on the weight of the resident as to how fast this would happen. She stated this feature was not used a lot but staff may need to use it for example if the battery did not work.

During an interview on 1/25/23 at 9:35 a.m., Staff F CNA stated she was getting ready to transfer Resident #4 out of bed and Staff I CNA went by

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F 600	Continued From page 3	F 600		

the room and stated she would help with the transfer. After Staff I left the area, the resident stated to Staff F that she did not care for Staff I because during a transfer she pulled the emergency release on the mechanical lift and she fell into bed and it hurt her. Staff F stated the resident reported that after this incident during subsequent transfers, Staff I acted like she was going to pull the emergency release. After the resident reported this to Staff F, Staff I returned to the room to assist with the transfer. Staff F stated as they were pulling the resident in the mechanical lift from the bed over to the recliner, Staff I reached down and put her hand on the emergency release and before Staff F could say anything the resident told Staff I not to touch that. Staff F stated Staff I then said she wasn't going to and was "kind of laughing". Staff F stated Staff I stated that she utilized the emergency release once with the resident and ever since then she(Staff I) acted like she was going to do it again to "get a rise out of her". Staff F stated she told Staff I that the resident disliked her because of this. Staff F stated it did not cross her mind that this was abuse and she did not report it but stated about a half an hour later Staff J Assistant Director of Nursing(ADON) came and asked her about the incident.

During an interview on 1/25/23 at 10:14 a.m., Staff G CNA stated Resident #4 told her she did not like Staff I.

During an interview on 1/25/23 at 2:30 p.m., Resident #5 confirmed that it was Staff I who used the emergency release with Resident #4. He stated he did not feel like this act was "mean spirited" but stated it hurt Resident #4. Resident #4 arrived during the interview and stated when

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F 600	Continued From page 4	F 600		

Staff I utilized the emergency release it made her mad and really upset her. Staff #4 stated it made her really mad because Staff I thought it was so funny.

During an interview on 1/26/23 at 2:04 p.m., Staff I stated Resident #4 told her 2 months ago that another staff member utilized the emergency release on the lift and dropped her into bed. Staff I stated she(Staff I) joked around with everyone and told the resident that she was going to tease her about it. She stated after the resident told her that, every time she would go in there, she would move her hand down to the emergency release button but would not push it. Staff I stated she never used the emergency release button. She stated when she teased the resident and did this the resident would say "don't you do that" and they would both laugh(Staff I and the resident). Staff I stated she thought the resident mistakenly thought is was her(Staff I) who used the emergency release but it was not. Staff I stated Resident #4 and #5 were some of her favorite residents in the facility and that her father used to work for Resident #5. Staff I stated she thought maybe she just caught Resident #4 on a bad day and stated she would be scared if someone dropped her(Staff I) in the lift. She stated she would not go out of her way to make someone feel uncomfortable.

The facility policy "Lifting Machine, Using a Mechanical" revised July of 2017, stated the purpose of the procedure was to establish the general principles of safe lifting using a mechanical lift. The policy directed staff to slowly lower the resident to the receiving surface.

The facility policy "Abuse, Neglect, Exploitation

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F 600	Continued From page 5 and Misappropriation Prevention Program", revised April 2021, stated residents had the right to be free from abuse which included corporal punishment, verbal abuse, mental abuse, and physical abuse. The policy stated if the alleged perpetrator was an employee or staff member, the individual was immediately reassigned to duties that did not involve residents. The policy defined "abuse" as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. During an interview on 1/31/23 at 1:04 p.m., the Administrator stated he expected staff to treat residents with respect and dignity and stated staff was there for the residents. He stated Staff I admitted to him that she used the emergency release with Resident #4. The Administrator stated Staff I stated that she and the resident laughed about it and it was a running joke that she would put her hand by the emergency release button.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 609	**Description:** 609 Reporting of alleged violations **Plan of Correction:** Education provided to staff regarding reporting alleged violations. **How residents affected & residents with potential of being affected were identified:** Residents who reside to Oakwood Specialty Care have the potential to be affected.	

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F 609	Continued From page 6 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, policy review, staff interview, and resident interview, the the facility failed to ensure staff reported an allegation of abuse to facility management in a timely manner for 1 of 1 residents reviewed for an allegation of abuse(Resident #4). The facility reported a census of 36 residents. Findings Include: 1. The Quarterly Minimum Data Set (MDS) assessment tool, dated 12/30/22, listed diagnoses for Resident #4 which included diabetes, pain in the right knee, and chronic pain syndrome. The MDS stated the resident required extensive assistance of 1 staff for personal hygiene, extensive assistance of 2 staff for bed mobility, transfers, dressing, and toilet use, and	F 609	**Corrective action taken for resident(s) affected:** Report completed to DIA. **Measures or systemic changes made to ensure this will not recur and affect others:** Education provided to staff regarding reporting alleged violations. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** 4 staff interviews per week for 4 weeks, then 2 staff interviews per for 4 weeks to assess for understanding of reporting requirements. Results of the interviews will be submitted to QAPI for further review.	

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F 609	Continued From page 7	F 609		

depended completely on 1 staff for bathing. The MDS listed the resident's BIMS(Brief Interview for Mental Status) score as 12 out of 15, indicating moderately intact cognition.

A Care Plan entry, dated 5/5/22, stated the resident utilized a Hoyer lift(a type of mechanical lift) with the assistance of 2 staff for transfers.

Staff I's Employee Punch Report for January 2023 documented she worked 6:30 a.m. -12:00 p.m. on 1/9/23.

The undated, untitled facility investigation stated the resident reported that staff dropped her in the Hoyer by pulling the emergency release and one staff laughed.

During an interview on 1/24/23 at 9:03 a.m., Resident #4 stated 2 Certified Nursing Assistants(CNAs) had her up in the Hoyer lift and one of the aides pulled the emergency release and she landed in the recliner and it hurt her. During the interview, Resident #4's husband was present (Resident #5). Resident #5 stated that he observed this event and after it happened the aide threatened to do it again during subsequent transfers and placed her hand on the emergency release. Resident #5 stated that the aide thought it was funny.

During an observation on 1/24/23 at 9:43 a.m., Staff L interim Director of Nursing(DON) and Staff K CNA transferred Resident #4 from her electric wheelchair into her bed using the EZ Lift (a type of mechanical lift). Staff F CNA then arrived and assisted with personal cares and then Staff K and Staff F transferred the resident back to the electric wheelchair using the lift.

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F 609	Continued From page 8 During an interview immediately after cares on 1/24/23 at 10:12 a.m., Staff F stated that the emergency release was located at the bottom of the center bar of the lift and in order to utilize it, one would pull it up. She stated when pulled, the resident would descend and it depended on the weight of the resident as to how fast this would happen. She stated this feature was not used a lot but staff may need to use it for example if the battery did not work. During an interview on 1/25/23 at 9:35 a.m., Staff F CNA stated she was getting ready to transfer Resident #4 out of bed and Staff I CNA went by the room and stated she would help with the transfer. After Staff I left the area, the resident stated to Staff F that she did not care for Staff I because during a transfer she pulled the emergency release on the mechanical lift and she fell into bed and it hurt her. Staff F stated the resident reported that after this incident during subsequent transfers, Staff I acted like she was going to pull the emergency release. After the resident reported this to Staff F, Staff I returned to the room to assist with the transfer. Staff F stated as they were pulling the resident in the mechanical lift from the bed over to the recliner, Staff I reached down and put her hand on the emergency release and before Staff F could say anything the resident told Staff I not to touch that. Staff F stated Staff I then said she wasn't goingto and was "kind of laughing". Staff F stated Staff I stated that she utilized the emergency release once with the resident and ever since then she(Staff I) acted like she was going to do it again to "get a rise out of her". Staff F stated she told Staff I that the resident disliked her because of this. Staff F stated it did not cross her mindthat	F 609		

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this was abuse and she did not report it but stated about a half an hour later Staff J Assistant Director of Nursing(ADON) came and asked her about the incident.

During an interview on 1/25/23 at 10:14 a.m., Staff G CNA stated Resident #4 told her she did not like Staff I.

During an interview on 1/25/23 at 2:30 p.m., Resident #5 confirmed that it was Staff I who used the emergency release with Resident #4. He stated he did not feel like this act was "mean spirited" but stated it hurt Resident #4. Resident #4 arrived during the interview and stated when Staff I utilized the emergency release it made her mad and really upset her. Staff #4 stated it made her really mad because Staff I thought it was so funny.

During an interview on 1/26/23 at 2:04 p.m., Staff I stated Resident #4 told her 2 months ago that another staff member utilized the emergency release on the lift and dropped her into bed. Staff I stated she (Staff I) joked around with everyone and told the resident that she was going to tease her about it. She stated after the resident told her that, every time she would go in there, she would move her hand down to the emergency release button but would not push it. Staff I stated she never used the emergency release button. She stated when she teased the resident and did this the resident would say "don't you do that" and they would both laugh (Staff I and the resident). Staff I stated she thought the resident mistakenly thought is was her (Staff I) who used the emergency release but it was not. Staff I stated Resident #4 and #5 were some of her favorite residents in the facility and that her father used to

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F 609	Continued From page 10	F 609		

work for Resident #5. Staff I stated she thought maybe she just caught Resident #4 on a bad day and stated she would be scared if someone dropped her(Staff I) in the lift. She stated she would not go out of her way to make someone feel uncomfortable.

The facility policy "Lifting Machine, Using a Mechanical" revised July of 2017, stated the purpose of the procedure was to establish the general principles of safe lifting using a mechanical lift. The policy directed staff to slowly lower the resident to the receiving surface.

The facility policy "Abuse, Neglect, Exploitation and Misappropriation Prevention Program", revised April 2021, stated residents had the right to be free from abuse which included corporal punishment, verbal abuse, mental abuse, and physical abuse. The policy stated if the alleged perpetrator was an employee or staff member, the individual was immediately reassigned to duties that did not involve residents. The policy defined "abuse" as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.

The facility policy "Timely Abuse Reporting", dated November 2019, stated all allegations of resident abuse should be reported immediately to the Charge Nurse.

During an interview on 1/31/23 at 8:26 a.m., the Director of Nursing(DON) stated that if a resident informed a staff member that another staff member mistreated the resident, she expected the staff member to report it immediately and would not want the staff member to work with the

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F 609	Continued From page 11 resident again. During an interview on 1/31/23 at 1:04 p.m., the Administrator stated he expected staff to treat residents with respect and dignity and stated staff was there for the residents. He stated Staff I admitted to him that she used the emergency release with Resident #4. The Administrator stated Staff I stated that she and the resident laughed about it and it was a running joke that she would put her hand by the emergency release button.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, policy review, staff interview, and resident interview, the the facility failed to ensure	F 610	**Description:** F 610 Investigate/Prevent/Correct Alleged Violation **Plan of Correction**: Education provided to management staff regarding investigation policy **How residents affected & residents with potential of being affected were identified:** Residents who reside to Oakwood Specialty Care have the potential to be affected. **Corrective action taken for resident(s) affected:** N/A **Measures or systemic changes made to ensure this will not recur and affect others:** Administrator will assess each event that requires investigation to determine if witnesses are available. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Administrator will review all investigations and assure that staff interviews have been completed and documented from all known witnesses.	

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protection of a victim after an allegation of abuse for 1 of 1 residents reviewed for an allegation of abuse(Resident #4). The facility reported a census of 36 residents.

Findings Include:

1. The MDS(Minimum Data Set) assessment tool, dated 12/30/22, listed diagnoses for Resident #4 which included diabetes, pain in the right knee, and chronic pain syndrome. The MDS stated the resident required extensive assistance of 1 staff for personal hygiene, extensive assistance of 2 staff for bed mobility, transfers, dressing, and toilet use, and depended completely on 1 staff for bathing. The MDS listed the resident's BIMS (Brief Interview for Mental Status) score as 12 out of 15, indicating moderately intact cognition.

A Care Plan entry, dated 5/5/22, stated the resident utilized a hoyer lift(a type of mechanical lift) with the assistance of 2 staff for transfers.

Staff I's Employee Punch Report for January 2023 documented she worked 6:30 a.m. -12:00 p.m. on 1/9/23.

The undated, untitled facility investigation stated the resident reported that staff dropped her in the hoyer by pulling the emergency release and one staff laughed.

During an interview on 1/24/23 at 9:03 a.m., Resident #4 stated 2 Certified Nursing Assistants (CNAs) had her up in the hoyer lift and one of the aides pulled the emergency release and she landed in the recliner and it hurt her. During the interview, Resident #4's husband was present

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(Resident #5). Resident #5 stated that he observed this event and after it happened the aide threatened to do it again during subsequent transfers and placed her hand on the emergency release. Resident #5 stated that the aide thought it was funny.

During an observation on 1/24/23 at 9:43 a.m., Staff L interim Director of Nursing (DON) and Staff K CNA transferred Resident #4 from her electric wheelchair into her bed using the EZ Lift (a type of mechanical lift). Staff F CNA then arrived and assisted with personal cares and then Staff K and Staff F transferred the resident back to the electric wheelchair using the lift.

During an interview immediately after cares on 1/24/23 at 10:12 a.m., Staff F stated that the emergency release was located at the bottom of the center bar of the lift and in order to utilize it, one would pull it up. She stated when pulled, the resident would descend and it depended on the weight of the resident as to how fast this would happen. She stated this feature was not used a lot but staff may need to use it for example if the battery did not work.

During an interview on 1/25/23 at 9:35 a.m., Staff F CNA stated she was getting ready to transfer Resident #4 out of bed and Staff I CNA went by the room and stated she would help with the transfer. After Staff I left the area, the resident stated to Staff F that she did not care for Staff I because during a transfer she pulled the emergency release on the mechanical lift and she fell into bed and it hurt her. Staff F stated the resident reported that after this incident during subsequent transfers, Staff I acted like she was going to pull the emergency release. After the

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resident reported this to Staff F, Staff I returned to the room to assist with the transfer. Staff F stated as they were pulling the resident in the mechanical lift from the bed over to the recliner, Staff I reached down and put her hand on the emergency release and before Staff F could say anything the resident told Staff I not to touch that. Staff F stated Staff I then said she wasn't going to and was "kind of laughing". Staff F stated Staff I stated that she utilized the emergency release once with the resident and ever since then she(Staff I) acted like she was going to do it again to "get a rise out of her". Staff F stated she told Staff I that the resident disliked her because of this. Staff F stated it did not cross her mind that this was abuse and she did not report it but stated about a half an hour later Staff J Assistant Director of Nursing(ADON) came and asked her about the incident.

During an interview on 1/25/23 at 10:14 a.m., Staff G CNA stated Resident #4 told her she did not like Staff I.

During an interview on 1/25/23 at 2:30 p.m., Resident #5 confirmed that it was Staff I who used the emergency release with Resident #4. He stated he did not feel like this act was "mean spirited" but stated it hurt Resident #4. Resident #4 arrived during the interview and stated when Staff I utilized the emergency release it made her mad and really upset her. Staff #4 stated it made her really mad because Staff I thought it was so funny.

During an interview on 1/26/23 at 2:04 p.m., Staff I stated Resident #4 told her 2 months ago that another staff member utilized the emergency release on the lift and dropped her into bed. Staff

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I stated she(Staff I) joked around with everyone and told the resident that she was going to tease her about it. She stated after the resident told her that, every time she would go in there, she would move her hand down to the emergency release button but would not push it. Staff I stated she never used the emergency release button. She stated when she teased the resident and did this the resident would say "don't you do that" and they would both laugh(Staff I and the resident). Staff I stated she thought the resident mistakenly thought is was her(Staff I) who used the emergency release but it was not. Staff I stated Resident #4 and #5 were some of her favorite residents in the facility and that her father used to work for Resident #5. Staff I stated she thought maybe she just caught Resident #4 on a bad day and stated she would be scared if someone dropped her(Staff I) in the lift. She stated she would not go out of her way to make someone feel uncomfortable.

The facility policy "Lifting Machine, Using a Mechanical" revised July of 2017, stated the purpose of the procedure was to establish the general principles of safe lifting using a mechanical lift. The policy directed staff to slowly lower the resident to the receiving surface.

The facility policy "Abuse, Neglect, Exploitation and Misappropriation Prevention Program", revised April 2021, stated residents had the right to be free from abuse which included corporal punishment, verbal abuse, mental abuse, and physical abuse. The policy stated if the alleged perpetrator was an employee or staff member, the individual was immediately reassigned to duties that did not involve residents. The policy defined "abuse" as the willful infliction of injury,

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F 610	Continued From page 16 unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. During an interview on 1/31/23 at 8:26 a.m., the Director of Nursing(DON) stated that if a resident informed a staff member that another staff member mistreated the resident, she expected the staff member to report it immediately and would not want the staff member to work with the resident again. During an interview on 1/31/23 at 1:04 p.m., the Administrator stated he expected staff to treat residents with respect and dignity and stated staff was there for the residents. He stated Staff I admitted to him that she used the emergency release with Resident #4. The Administrator stated Staff I stated that she and the resident laughed about it and it was a running joke that she would put her hand by the emergency release button.	F 610		
F 695 SS=J	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, family and staff interviews and facility policy review, the facility	F 695	**Description: F695** **Plan of Correction:** • Staff education provided regarding the location of Crash Cart (stored behind the nurses' station in the CNA Room). • Staff Education provided regarding the equipment available to them on the crash cart for suctioning. • Staff education will be completed prior to admitting residents with a tracheostomy regarding tracheostomy course assigned in Relias with post course test, tracheal suctioning competency, tracheostomy cleaning, supplies readily available at bedside, humidification systems, tracheostomy assessments, how to handle extubation and suctioning procedures	

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F 695	Continued From page 17 failed to assure that staff provided appropriate tracheostomy care to include the assessment of respiratory failure and failed to provide appropriate training to nursing staff on procedures during an accidental extubation (tracheostomy tube fall out), tracheostomy care and suctioning for 1 of 1 resident (Resident #12). This failure resulted in the transport by MedAir to a hospital and placed on mechanical ventilation therefore causing an Immediate Jeopardy to the health, safety, and security of the resident. The facility identified a census of 36 residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of July 27, 2022 on January 26, 2023 at 10:45 A.M. The facility staff removed the Immediate Jeopardy on January 26, 2023 through the following actions: a. Staff education provided regarding the location of the crash cart (stored behind the nurse's station in the CNA room. b. Staff education provided regarding on the equipment available to them on the crash cart for suctioning. c. Staff education will be completed prior to admitting residents with a tracheostomy tube regarding a tracheostomy course assigned in Relias with a course posttest, tracheal suctioning competency, tracheostomy cleaning, supplies readily available at bedside, humidification systems, tracheostomy assessments, how to handle extubation, and suctioning procedures for future emergency situations. d. Staff education regarding contacting the on-call nurse with any questions on equipment that cannot be located. e. Night nurse will review crash cart supply checklist and complete nightly.	F 695	for future emergency situations. • Staff education provided regarding contacting the on-call nurse with any questions on equipment that cannot be located. • Night nurse will review crash cart supplies checklist and complete nightly. **How residents affected & residents with potential of being affected were identified:** Residents with tracheostomies who reside to Oakwood Specialty Care have the potential to be affected. Effective 11.19.22 no residents requiring tracheostomy care reside to the facility. **Corrective action taken for resident(s) affected:** Resident transferred to Albia Hospital for immediate care. **Measures or systemic changes made to ensure this will not recur and affect others:** • Nursing staff will be educated regarding above plan of correction during orientation process. • Facility will continue with current plan of correction to complete orientation checklists upon hire. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Routine audits will be conducted to assure ongoing orientation to process continues and tracheostomy education is provided to new employees. Results of the audits will be submitted to QAPI for review and additional recommendations.	

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F 695	Continued From page 18 Measures or systemic changes made to ensure this will not recur and affect others: Nursing staff and Agency nursing staff will be educated regarding above plan of correction during orientation process. Facility will continue with current plan of correction to complete orientation checklists upon hire. Binder including above listed education will be placed at nurses' station with education sign off to assure that new nursing staff (Facility and agency) are educated appropriately. The scope lowered from "J" to "D" at the time of the survey after ensuring the facility implemented education and their policy and procedures. Findings Include: 1. The Quarterly Minimum Data Set (MDS) dated 10/27/22 documented Resident#12 had the diagnoses including diagnosis of heart failure, respiratory failure, tracheostomy, obesity and obstructive sleep apnea. The MDS documented that the resident required extensive assist with bed mobility, dressing and toilet use from 2 persons. Resident #12 had a Brief Interview for Mental Status (BIMS) of 15 out of 15 which suggested an intact cognition. The Care Plan dated 10/25/22 directed staff to administer oxygen as ordered, change the tubing as the protocol directs, provide humidification and suction as needed and monitor for changes that may indicate worsening respiratory status and report it to the physician. The care plan did not address the tracheostomy or care for	F 695		

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tracheostomy.

The physician order received by phone on 7/24/22, may suction trach every 4 hours and as needed every 4 hours.

The physician order received on 7/27/22 directed staff to clean tracheostomy 1 time a week and prn, resident will clean tracheostomy other days, and change oxygen tubing weekly.

The physician order received 10/21/22 directed staff to fill humidification chamber with distilled water every evening and as needed.

On 11/19/22 Situation, Background, Assessment, Recommendation (SBAR) documentation at 8:20 AM, Staff B, Director of Nursing (DON) revealed a change of condition for Resident #12, shortness of breath, generalized weakness, skin discoloration, and an altered level of consciousness and reported vital signs of Blood pressure 128/88, pulse 75, respiration 20, temperature 98.9 and oxygen saturation 89% with recommendation of Emergency room.

On 11/19/22 Focused Evaluation documentation at 5 PM Staff C, Registered Nurse (RN) revealed Resident #12 refused medication, experienced nausea, finger tips cyanotic (white color) and unable to obtain oxygen saturation, vital signs blood pressure 97/73, pulse 92, respiration 20, temperature 97.6, resident refused to have lung sound and abdomen assessed, notified physician, no new order, Resident #12 refused offer to go to the hospital during day shift 3 times.

Document titled Mercy Medical Center Final Report dated 11/29/22 revealed Resident #12

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with a chronic tracheostomy was treated in the Monroe County Emergency Room for acute hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), was suctioned and a large amount of tan secretions returned, WBC count 21.1 (normal 4.5 - 11), chest x-ray revealed pulmonary (lung) congestion with bilateral pleural effusions (buildup of fluid in the tissues that line the lungs). Resident #12 was transported by AirMed to Mercy Hospital for diagnosis of severe hypoxic respiratory failure where they removed the tracheostomy tube and replaced it, performed a bronchoscopy (a procedure that lets the doctor look at the lungs and air passages) which revealed thick secretions in both lungs that were removed with suctioning. Resident #12 was placed on mechanical ventilation and intravenous (IV) antibiotic.

On 1/24/23 at 11:32 AM, a family of Resident #12 stated the resident was in the intensive care unit on a ventilator due to pneumonia that she acquired at the nursing facility and the nursing facility would not take her back unless Resident #12 signed a do not resuscitate (DNR) form, and Resident #12 was not going to sign a DNR form, "she is still young and a fighter".

During an interview on 1/25/23 at 3:08 PM Staff E, Licensed Practical Nurse (LPN), stated she worked the evening of 11/19/22 and did not receive information in report that Resident #12 was sick, a CNA reported Resident #12 was short of breath. Staff E stated found Resident #12's skin color to be ashen (gray), "hypoxic" and Resident #12 told Staff E she was afraid to go to the hospital. Staff E stated she looked for a nebulizer order and machine, could not find one and could not find suction catheters that were to

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be at bedside. Staff E stated, "That was the #1 problem, it was a disaster". Staff E stated Staff H notified 911 and the physician while she brought the crash cart to the room for fear that the resident would code. Staff E stated, "I'm an ER nurse and I had nothing to help her".

During an interview on 1/25/23 at 4:25 PM Staff H, RN, stated she convinced Resident #12 to go to the hospital and called 911 on the evening of 11/19/22. Staff H stated she had knowledge of trach care before working at this facility and passed on several times in report that the trach needed to be plugged during the day time and open during the evening or more trach care would need to be done, and Resident #12 told her the day staff wouldn't plug it and the staff told her that Resident #12 refused to plug it. Staff H stated the obturator and tracheostomy cannula (tube) were not at bedside, as Staff M, Director of Nursing (DON) directed to have them kept in the crash cart which is in a closed room at the nurse's station. Staff H stated when the new DON came, that was not re-addressed. Staff H stated "The other nurses were nervous to take care of the trach, they did not know enough about it". Staff H stated the inner cannula of the tracheostomy tube was to be cleansed every day and she was aware that the resident was not doing it. Staff H stated, "She didn't have a mirror to suction or take it out, she wasn't doing it". Staff H stated she did not know who would place a new tracheostomy tube if it came but she had to do it one time for Resident #12 and the humidification container was empty several times when she came in to work.

During an interview on 1/25/23 at 1:26 PM Staff N, LPN stated she did suction Resident #12's

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tracheostomy 1 time, "because someone else didn't know how to". Staff N stated Resident #12 was to perform her own tracheostomy care and had not actually seen Resident #12 do her own tracheostomy care, "I wasn't in her room much".

During an interview on 1/25/23 at 12:30 PM, Staff B, (Interim DON #1), stated she had not performed tracheostomy care for Resident #12 while she was the DON at this facility and had not observed other nursing staff provide care for Resident #12. Staff B did not know what was at Resident #12's bedside for the tracheostomy care.

During an interview on 1/24/23 at 2:55 PM Staff L, (interim DON) stated she started work at the facility a week after Resident #12 was transported to the hospital, had conversation with the hospital respiratory therapy department and Resident #12 was barley maintaining at 10 liters of oxygen and a full code status and had asked if Resident #12 could be weaned down to 7 or 8 liters of oxygen and was told it was not possible at that time. The DON stated a conversation with a female physician who asked if the facility would take Resident #12 if on a no code status, and the DON stated they would if a Do Not Resuscitate (DNR) status was obtained. The DON stated she had not spoken with family about the DNR status and it was not a mandate from her or corporate to make the resident a DNR.

During an interview on 1/26/23 at 1:16 PM Staff O, LPN stated there was a lady who came in with the supplies the day before Resident #12 was admitted and she didn't get the training. Staff O stated Resident #12 would instruct how to do the care that she wanted, "I had no idea how to do it".

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F 695	Continued From page 23 Oxygen Policy dated October 2010 revealed: Oxygen equipment #3. humidification bottle Assessment #2 signs and symptoms of hypoxia (lack of oxygen) Steps in procedure #9 check mask, tank and humidifying jar to be sure there is water in the humidifying jar and water level is high enough that the water bubbles as oxygen flows through #11 periodically re-check water level in the humidifying jar and document oxygen flow rate. Tracheostomy care dated 2013 revealed: General guidelines #2 gloves are to be clean and sterile #6 a replacement tracheostomy tube must be available at the bedside at all times #7 Suction machine and a supply of suction catheters, sterile gloves and flush solution must be at bed side at all times Procedure guidelines #7 listen to lung sounds with a stethoscope Site and Stoma Care #2 clean stoma site with peroxide-soaked solution, rinse with saline soaked gauze, and disinfect stoma with antiseptic gauze, single sweep for each side, air dry, apply gauze around stoma site. During an interview on 1/26/23 at 12:55 PM, Staff P, LPN stated she had been assigned to the Relias training for tracheostomy care, visualized the binder with the training, oriented to the crash cart and its contents and is aware of the on-call nurse schedule to call for assistance if needed. During an interview on 1/26/23 at 12:58 PM Staff E, LPN stated she has completed an orientation training, reviewed the tracheostomy training, visualized the binder with the training and was	F 695		

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F 695	Continued From page 24 oriented to the crash cart and its content. During an interview on 1/26/23 at 12:50 PM the Regional Director of Clinical Services stated that the care plans for tracheostomy residents will include detailed directions for the nurses. Observation on 1/26/23 at 12:50 PM the training book for tracheostomy care, oxygen humidification set up and suction set up was complete and had descriptive pictures was located at the nurse station. The crash cart located in the room connected to the nurse station was stocked with tracheostomy and suction supplies and the crash cart check off list located on the top of the crash cart. During an interview on 1/26/23 at 1:46 PM the Administrator stated evaluation of nursing staff will be completed and was confident the staff will be capable to care for future residents with a tracheostomy as there will be a follow up with staff and resident to be sure. During an interview/observation on 1/25/23 at 3:20 p.m., Staff D Corporate Nurse pointed out a suction machine in Room 67 which had Resident #12's name on it. The suction machine had a canister and tubing coming out of the canister but lacked a suction catheter.	F 695		

Northwest Respiratory Services Facility Census List

Oakwood Specialty Care - 200 16th Ave East Care Initiatives - Albia, IA 52531 (641)-932-7105 ID# 110301

Facility Notes: No notes on File

CENSUS	#B/U	B/U PER PT	EST. #B/U	CYL INV.**
4	3	12	2	12

Facility Access Codes: No Codes on File

**Verify and update Cylinder Inventory with every delivery to Facility

PATIENT NAME (FIRST LAST)	ID#	RM	EQUIP.	MODEL	S/N	PREVIOUS HRS	PREVIOUS DATE	CURRENT HRS	CURRENT DATE	PORT	CYL USED	T?	D/C - EXCH
LINDA DEGROFFT	TBD	21	CONC	EVERFLO	222020	38,741	11/21/22	39060	2-28	HPP			
FLORENCE 'ELAINE' HOPKINS	292294	27	CONC	VISION	V0403552	18,743	12/19/22	Missing					passed 1-26 ✓
THELMA CALLEN	226623	46	CONC	VISION	V0228612	19,297	11/21/22	21726	2-28	HPP			
RAYMON VITKO	262758	47	CONC	EVERFLO	BU 211707	23,657	11/21/22	25673	2-28	HPP			passed 2-7-23 ✓

BACK-UP EQUIPMENT - NEW SET-UPS/EXCHANGES

PATIENT NAME (FIRST LAST)	ID#	RM	EQUIP.	MODEL	S/N	HRS	DATE	HRS	DATE	PORT	CYL USED	T?	D/C - EXCH
Broken Pick up		BU	CONC	EVERFLO	274875	4,769	10/11/22	4769	2-28	Pick up			
			CONC	EVERFLO	226387	928	10/25/22	Both Have been Picked up in Jan					
			CONC	EVERFLO	287440	28,866	11/7/22						
		BU	Conc	EF	382769	9897	2-28						

EQUIPMENT PROCESSING LOG

MODEL - S/N	DATE	HRS	CLEAN INT.	CLEAN EXT.	O2% @ FLOW	ELEC.	ALARM	FILTER	LEAK CK	GAUGE CK	LOCATION		INITIALS

TURN IN SHEET WITH DELIVERY TICKETS

PRINT DATE: