PRINTED: 03/01/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		E SURVEY PLETED
							С
		165313	B. WING			01	/31/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKWOO	D SPECIALTY CARE			l	200 16TH AVENUE EAST		
				<i></i>	ALBIA, IA 52531		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	.–	(X5) COMPLETION
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		2/20/23
F 000	INITIAL COMMENTS	3	F	000			
🗸							
ok/CP	Correction Date 2-2						
		the survey ending October					
		gation of Complaints # C, #109446-C, #109887-C,			·		
		ity Self-Reported Incident					
		icted January 23, 2023 to					
	January 31, 2023. Th	e results for the Facility					
	•	nt #110480-M will be sent to					
	the facility at a later d	late under a separate cover.					
	All deficiencies were	corrected for the revisit, but					
	additional deficiencies	s were cited from the					
	complaint investigation	on.					
	Complaints # 109446	C #100997 C and					
	#110160-C were sub						
	#110100 O Wele bub	otalitatos.					
	See code of Federal	Regulations (42 CFR), Part					
	483, Subpart B-C.						
							:
F 600	Free from Abuse and	Neglect	-	600			
I	CFR(s): 483.12(a)(1)	=		600			
	5111(6). 100.122(d)(1)						
	0.400.4015   5				- 44 F000 F - AI		
	-	m Abuse, Neglect, and			Description: F600 Free From Abuse and Plan of Correction: Staff will be educated		1
	Exploitation  The resident has the	right to be free from abuse,			the definition of abuse and neglect. Edu		
		ation of resident property,			provided to staff regarding reporting alle		
		efined in this subpart. This			violations.		
	includes but is not lim	nited to freedom from			How residents affected & residents w	rith	
		involuntary seclusion and			potential of being affected were ident		
	• • •	ical restraint not required to			Residents that reside to Oakwood Spec		
	treat the resident's m	edicai symptoms.			Care have the potential to be affected		
	§483.12(a) The facilit	v must-					
	3 .50. Ta(a) The identi	y made					
LABORATORYD	IRECTOR'S ØR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATUR	 RE		TITLE		(X6) DATE

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.

OFILE	OT OIT MEDION AND ON	TEDIOTIB OF THESE					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	*****		A. BUILDIN	G	,	С	
		165313	B. WING_		01/	31/2023	
NAME OF PI	ROVIDER ORSUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	=		
OVRIMOO	DSPECIALTYCARE		ł	200 16TH AVENUE EAST			
CARWOO	DOFECIALITOANE			ALBIA, IA 52531			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LISC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From pag	e 1	F6	00			
	physical abuse, corp involuntary seclusion This REQUIREMEN' by: Based on observation policy review, staff in interview, the the factoresidents was free free			Corrective action taken for resaffected: Staff member terminate Measures or systemic change ensure this will not recur and a Staff will be educated on the defand neglect. Education provided regarding reporting alleged viola Way lift Operator's manual with i proper use of the Emergency Rehas been attached to the lifts for Planned monitoring of correct ensure practice is corrected at occur: 4 Audits per week of staff	s made to affect others: inition of abuse to staff tions.An Easy instructions on elease button easy reference. tive actions to nd will not ff knowledge		
	assessment tool, dat diagnoses for Reside diabetes, pain in the syndrome. The MDS extensive assistance hygiene, extensive a mobility, transfers, d depended completel MDS listed the resid Mental Status) score indicated moderately	ent #4 which included right knee, and chronic pain stated the resident required e of 1 staff for personal assistance of 2 staff for bed ressing, and toilet use, and y on 1 staff for bathing. The ent's BIMS(Brief Interview for e as 12 out of 15, which y intact cognition.		regarding abuse and neglect will on staff for 4 weeks. Then 2 Austaff knowledge regarding abuse be conducted on staff for 2 addit Audits per week of staff conduct with a Hoyer Lift for 4 weeks. The week for an additional week. Results of audits will be submitted further review.	dits per week of e and neglect will tional weeks. 2 ing transfers en 1 Audit per		
	resident utilized a Ho lift) with the assistan Staff I's Employee P	ated 5/5/22, stated the over lift (a type of mechanical ce of 2 staff for transfers.  Tunch Report for January he worked 6:30 a.m12:00					
		d facility investigation stated					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ICATION NUMBER		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		165313	165313 B. WING		į.	C	
NAME OF D	BOVIDED OD SUBBLIED	100010			TOTAL ADDRESS SITE STATE TO SOON	01/	/31/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
OAKWOO	D SPECIALTY CARE				200 16TH AVENUE EAST		
		***		_	ALBIA, IA 52531		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
IAO		,	1,10	,	DEFICIENCY)	,,,,	
F 600	Continued From page	e 2	F	600			
	Hoyer by pulling the	emergency release and one					
	staff laughed.						
	During an interview o	n 1/24/23 at 9:03 a.m.,					
	Resident #4 stated 2						
		d her up in the Hoyer lift and					
		ed the emergency release					
		recliner and it hurt her.					
	During the interview,	Resident #4's husband was					
	present(Resident #5)	. Resident #5 stated that he					
		and after it happened the					
		it again during subsequent					
		her hand on the emergency					
		stated that the aide thought					
	it was funny.						
	During an observation	n on 1/24/23 at 9:43 a.m.,					
		r of Nursing(DON) and Staff					
		esident #4 from her electric					
	wheelchair into her be	ed using the EZ Lift(a type of					
	mechanical lift). Staff	F CNA then arrived and					
		li cares and then Staff K and					
	Staff F transferred the						
	electric wheelchair us	sing the lift.					
	During an interview in	nmediately after cares on					
		, Staff F stated that the					
		as located at the bottom of					
		ift and in order to utilize it,					
		She stated when pulled, the					
		nd and it depended on the					
		as to how fast this would				ļ	
		nis feature was not used a				ļ	
		to use it for example if the					
	battery did not work.						
	D	- 4/05/00 -4 0:05 - ··· 01 **					
		n 1/25/23 at 9:35 a.m., Staff				ļ	
		s getting ready to transfer d and Staff I CNA went by				ļ	
l	Leginetif #4 Ont of be	u anu otan i CNA Went by			1	l	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		165313	B. WING		01/31/2023			
	ROVIDER ORSUPPLIER	<u> </u>	;	STREET ADDRESS, CITY, STATE, ZIP CODE  200 16TH AVENUE EAST  ALBIA, IA 52531				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION			
F 600	the room and stated transfer. After Staff stated to Staff F that because during a tremergency release fell into bed and it has because during a tremergency release fell into bed and it has because during the resident reported the subsequent transfe going to pull the errosident reported the room to assist where stated as they were mechanical lift from Staff I reached down emergency release anything the reside Staff F stated Staff and was "kind of last stated that she utilized once with the reside she (Staff I) acted lift to "get a rise out of Staff I that the reside this. Staff F stated this was abuse and about a half an hour Director of Nursing about the incident.  During an interview Staff G CNA stated not like Staff I.  During an interview Resident #5 confirmused the emergency He stated he did not spirited" but stated	d she would help with the I left the area, the resident at she did not care for Staff I ansfer she pulled the on the mechanical lift and she purt her. Staff F stated the part after this incident during res, Staff I acted like she was bergency release. After the pulling the resident in the lift the bed over to the recliner, remand put her hand on the lift and before Staff F could say and before Staff F could say to to to to to the tat. I then said she wasn't going to be ughing". Staff F stated Staff I lift lift lift lift lift lift lift lift	F 600					

1 ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , , , , , , , , , , , , , , , , , , ,		, ,	(X3) DATE SURVEY COMPLETED	
		165313 B. WING				C 0 <b>1/31/2023</b>	
	ROVIDER OR SUPPLIER	<b>L</b>		STREET ADDRESS, CITY, STATE, ZIP CODE 200 16TH AVENUE EAST ALBIA, IA 52531		7110112020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR: (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	Staff I utilized the em mad and really upset her really mad becau funny.  During an interview of I stated Resident #4 to another staff member release on the lift and I stated she (Staff I) journed to to the resident her about it. She state that, every time she would not never used the emergistated when she teast the resident would not never used the emergistated when she teast the resident would sate they would both laugh Staff I stated she thou thought is was her (Stemergency release by Resident #4 and #5 were sident #4 and #5 were sident #5. maybe she just caugh and stated she would dropped her (Staff I) in would not go out of he feel uncomfortable.  The facility policy "Liff Mechanical" revised of the process of the process general principles of signechanical lift. The plower the resident to the state of the process general principles of signechanical lift. The plower the resident to the state of the process general principles of signechanical lift. The plower the resident to the state of the process general principles of signechanical lift. The plower the resident to the state of the process general principles of signechanical lift. The plower the resident to the state of the process general principles of signechanical lift. The plower the resident to the plotter of the process general principles of signechanical lift.	ergency release it made her her. Staff #4 stated it made se Staff I thought it was so in 1/26/23 at 2:04 p.m., Staff told her 2 months ago that rutilized the emergency if dropped her into bed. Staff oked around with everyone that she was going to tease ed after the resident told her would go in there, she would to the emergency release push it. Staff I stated she gency release button. She ed the resident and did this y "don't you do that" and in (Staff I and the resident). Light the resident mistakenly aff I) who used the ut it was not. Staff I stated vere some of her favorite y and that her father used to Staff I stated she thought in the Resident #4 on a bad day be scared if someone in the lift. She stated she er way to make someone ting Machine, Using a July of 2017, stated the dure was to establish the safe lifting using a olicy directed staff to slowly	F 6				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165313	B, WING		C <b>01/31/2023</b>
	ROVIDER OR SUPPLIER  D SPECIALTY CARE		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 16TH AVENUE EAST ALBIA, IA 52531	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 609 SS=D	revised April 2021, s to be free from abuse punishment, verbal a physical abuse. The perpetrator was an e the individual was im duties that did not in defined "abuse" as the unreasonable confin punishment with rese mental anguish.  During an interview of Administrator stated residents with respect was there for the residents with respect was there for the residents with Resider stated Staff I stated laughed about it and she would put her ha release button. Reporting of Alleged CFR(s): 483.12(b)(5) §483.12(c) In respon neglect, exploitation must: §483.12(c)(1) Ensur involving abuse, neg mistreatment, includ source and misappro are reported immedi hours after the alleg that cause the allegat	a Prevention Program", tated residents had the right which included corporal abuse, mental abuse, and policy stated if the alleged imployee or staff member, mediately reassigned to volve residents. The policy ne willful infliction of injury, ement, intimidation, or ulting physical harm, pain, or on 1/31/23 at 1:04 p.m., the he expected staff to treat and dignity and stated staff idents. He stated Staff I she used the emergency of #4. The Administrator that she and the resident it was a running joke that and by the emergency  Violations  Violations	F 600	Description: 609 Reporting of alleged violations  Plan of Correction: Education provided regarding reporting alleged violations.  How residents affected & residents w potential of being affected were ident Residents who reside to Oakwood Spec Care have the potential to be affected.	ith ified:

AND DI AN OS CODDECTION INDICATION MINADED:		1	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		165313	B. WING _			C / <b>31/2023</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 16TH AVENUE EAST ALBIA, IA 52531		1011/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 609	the events that cause abuse and do not rest the administrator of the officials (including to adult protective service for jurisdiction in long accordance with State procedures.  §483.12(c)(4) Report investigations to the adesignated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by:  Based on observation policy review, staff intinterview, the the facing reported an allegation management in a time residents reviewed for	the allegation do not involve ult in serious bodily injury, to me facility and to other the State Survey Agency and ces where state law provides term care facilities) in elaw through established  the results of all administrator or his or her ative and to other officials in elaw, including to the State in 5 working days of the eged violation is verified elaction must be taken. Tis not met as evidenced  in, clinical record review, terview, and resident lity failed to ensure staff in of abuse to facility ely manner for 1 of 1 ran allegation of The facility reported a	F 6	Corrective action taken for reside affected: Report completed to DIA.  Measures or systemic changes mensure this will not recur and affe Education provided to staff regardin alleged violations.  Planned monitoring of corrective ensure practice is corrected and occur: 4 staff interviews per week for understanding of reporting requires understanding of reporting requires alleged to five interviews will be sub QAPI for further review.	ade to ct others: g reporting actions to will not or 4 weeks, ks to assess ements.	
	assessment tool, date diagnoses for Reside diabetes, pain in the syndrome. The MDS extensive assistance hygiene, extensive as					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165313	B, WING				C 01/31/2023
	ROVIDER ORSUPPLIER DD SPECIALTY CARE			200 16	T ADDRESS, CITY, STATE, ZIP CODE TH AVENUE EAST A, IA 52531		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	l l	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 609	depended complet MDS listed the residental Status) so moderately intact of A Care Plan entry resident utilized a lift) with the assistants (Staff I's Employee 2023 documented p.m. on 1/9/23.  The undated, until the resident report Hoyer by pulling the staff laughed.  During an intervier Resident #4 stated Assistants (CNAs) one of the aides pand she landed in During the intervier present (Resident he observed this eaide threatened to transfers and place release. Resident it was funny.  During an observation of mechanical lift) assisted with persisted with	tely on 1 staff for bathing. The sident's BIMS(Brief Interview for one as 12 out of 15, indicating cognition.  I dated 5/5/22, stated the Hoyer lift(a type of mechanical ance of 2 staff for transfers.  Punch Report for January she worked 6:30 a.m12:00  Ided facility investigation stated and that staff dropped her in the ne emergency release and one  W on 1/24/23 at 9:03 a.m., If 2 Certified Nursing had her up in the Hoyer lift and ulled the emergency release the recliner and it hurt her.  Ew, Resident #4's husband was #5). Resident #5 stated that event and after it happened the do it again during subsequent ed her hand on the emergency #5 stated that the aide thought ation on 1/24/23 at 9:43 a.m., extor of Nursing(DON) and Staff it Resident #4 from her electric ar bed using the EZ Lift (a type and onal cares and then Staff K and it the resident back to the	F	609			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
						С	
		165313	B. WING _			01/31/2023	
	ROVIDER ORSUPPLIER  D SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 16TH AVENUE EAST ALBIA, IA 52531			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ON SHOULD BE CO IE APPROPRIATE		
F 609	1/24/23 at 10:12 a.m. emergency release we the center bar of the lone would pull it up. So resident would desce weight of the resident happen. She stated the lot but staff may need battery did not work.  During an interview of F CNA stated she was Resident #4 out of bethe room and stated stransfer. After Staff I I stated to Staff F that shecause during a transfer emergency release of fell into bed and it hui resident reported that subsequent transfers going to pull the emergency release of the room to assist wit stated as they were performed the median and the resident staff I reached down emergency release an anything the resident Staff F stated Staff I thand was "kind of lauge."	mmediately after cares on , Staff F stated that the ras located at the bottom of ift and in order to utilize it, She stated when pulled, the and and it depended on the as to how fast this would his feature was not used a lito use it for example if the in 1/25/23 at 9:35 a.m., Staff is getting ready to transfer and and Staff I CNA went by she would help with the eft the area, the resident she did not care for Staff I his fer she pulled the in the mechanical lift and she after this incident during the staff I returned to he the transfer. Staff F returned to he the transfer. Staff F utiling the resident in the ne bed over to the recliner, and put her hand on the not before Staff F could say told Staff I not to touch that, hen said she wasn't goingto hing". Staff F stated Staff I	F6	DEFICIENCY)			
	once with the residen she(Staff I) acted like to "get a rise out of he Staff I that the resider	d the emergency release t and ever since then she was going to do it again er". Staff F stated she told nt disliked her because of lid not cross her mindthat					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER		NG		COMPLETED	
	165313	B. WING_			C 01/31/2023	
NAME OF PROVIDER OR SUPPLIER  OAKWOOD SPECIALTY CARE		- I	STREET ADDRESS, CITY, STATE, ZIP CODE  200 16TH AVENUE EAST  ALBIA, IA 52531			
PREFIX (EACH DEFICIENCY I			PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE	
about a half an hour la Director of Nursing(AD about the incident.  During an interview on Staff G CNA stated Renot like Staff I.  During an interview on Resident #5 confirmed used the emergency rete stated he did not fe spirited" but stated it he #4 arrived during the in Staff I utilized the ememad and really upset her really mad becaus funny.  During an interview on I stated Resident #4 to another staff member release on the lift and I stated she (Staff I) jo and told the resident the rabout it. She state that, every time she we move her hand down the button but would not pnever used the emergestated when she teases the resident would say they would both laugh Staff I stated she thought is was her (Staff I) emergency release but the resident was her (Staff I) stated she thought is was her (Staff I) emergency release but the resident would say thought is was her (Staff I) about 1 and 1	e did not report it but stated ter Staff J Assistant ON) came and asked her 1/25/23 at 10:14 a.m., sident #4 told her she did 1/25/23 at 2:30 p.m., that it was Staff I who elease with Resident #4. ele like this act was "mean urt Resident #4. Resident nterview and stated when regency release it made her her. Staff #4 stated it made to Staff I thought it was so 1/26/23 at 2:04 p.m., Staff eld her 2 months ago that utilized the emergency dropped her into bed. Staff ked around with everyone hat she was going to tease differ the resident told her build go in there, she would to the emergency release ush it. Staff I stated she ency release button. She ad the resident and did this redon't you do that" and (Staff I and the resident). ght the resident mistakenly	F	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		165313	B. WING			C	
	ROVIDER ORSUPPLIER	100010	B. WINO	STREET ADDRESS, CITY, STATE, ZIP COD 200 16TH AVENUE EAST ALBIA, IA 52531	ÞΕ	01/3	1/2023
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE			
F 609	work for Resident #5 maybe she just caug and stated she would dropped her(Staff I) i would not go out of h feel uncomfortable.  The facility policy "Lif Mechanical" revised purpose of the proce general principles of mechanical lift. The p lower the resident to  The facility policy "Ak and Misappropriation revised April 2021, sit to be free from abuse punishment, verbal a physical abuse. The perpetrator was an e the individual was im duties that did not inv defined "abuse" as th unreasonable confine punishment with resu mental anguish.  The facility policy "Tir dated November 201 resident abuse shoul the Charge Nurse.  During an interview of Director of Nursing(D informed a staff mem member mistreated to	Staff I stated she thought ht Resident #4 on a bad day I be scared if someone n the lift. She stated she er way to make someone ting Machine, Using a July of 2017, stated the dure was to establish the	F6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
•	165313	B. WING	B. WING		C 01/31/2023	
OVIDER OR SUPPLIER SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 16TH AVENUE EAST ALBIA, IA 52531	<b>_</b>		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE	
resident again.  During an interview of Administrator stated in residents with respect was there for the residentited to him that strelease with Residentiated Staff I stated to the stated about it and she would put her ha	on 1/31/23 at 1:04 p.m., the he expected staff to treat at and dignity and stated staff idents. He stated Staff I she used the emergency t #4. The Administrator hat she and the resident it was a running joke that	F 60	09			
CFR(s): 483.12(c)(2) §483.12(c) In respon neglect, exploitation, must: §483.12(c)(2) Have exploitations are thorough §483.12(c)(3) Prever neglect, exploitation, investigation is in prof §483.12(c)(4) Report investigations to the designated represen accordance with Star Survey Agency, with incident, and if the al appropriate correctiv This REQUIREMEN' by: Based on observation	se to allegations of abuse, or mistreatment, the facility evidence that all alleged ghly investigated.  In further potential abuse, or mistreatment while the agress.  It the results of all administrator or his or her tative and to other officials in the law, including to the State in 5 working days of the leged violation is verified e action must be taken.  T is not met as evidenced on, clinical record review,	F 6*	Alleged Violation  Plan of Correction: Education programment staff regarding inventors.  How residents affected & residents of being affected were residents who reside to Oakwood Care have the potential to be affected: N/A  Corrective action taken for residents with a service change ensure this will not recur and administrator will assess each e requires investigation to determine available.  Planned monitoring of corrected a occur: Administrator will review and assure that staff interviews.	provided to estigation policy dents with re identified: od Specialty fected.  sident(s)  s made to affect others: vent that ne if witnesses tive actions to nd will not all investigations have been		
	SPECIALTY CARE  SUMMARY ST (EACH DEFICIENC' REGULATORY OR  Continued From page resident again.  During an interview of Administrator stated residents with respect was there for the residents with respect was there for the residents with Resident stated Staff I stated to the staff I stated to the stated St	DENTIFICATION NUMBER:  165313  DATABLE SPECIALTY CARE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 aughed about it and it was a running joke that she would put her hand by the emergency release button.  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)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  \$483.12(c)(4) Report the results of all linvestigations 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	DIDENTIFICATION NUMBER:  A. BUILDING  B. WING  DIDENTIFICATION NUMBER:  A. BUILDING  B. WING  DIDENTIFICATION NUMBER:  A. BUILDING  B. WING  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL.  REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 11  Fediate 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 aughed about it and it was a running joke that she would put her hand by the emergency release button.  Investigate/Prevent/Correct Alleged Violation  CFR(s): 483.12(c)(2)-(4)  S483.12(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 investigation is not neglect, exploitation, or mistreatment while the investigation is 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	IDENTIFICATION NUMBER:  165313  B. WINNS  STREET ADDRESS, CITY, STATE, ZIP CODE 200 14TH AVENUE EAST ALBIA, IA 52331  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 11  esident 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 stated that she and the resident aughed about it and it was a running joke that she would put her hand by the emergency release button.  Investigate/Prevent/Correct Alleged Violation CFFR(s): 483.12(c) (2)-(4)  S483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  S483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  S483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  S483.12(c)(4) Report the results of all investigation is in progress.  S483.12(c)(4) Report the results of all investigation is in progress.  S483.12(c)(4) Report the results of all investigation is in roorder.  S483.12(c)(4) Report the results of all investigation is in roorder.  S483.12(c)(4) Report the results of all investigation is in roorder.  S483.12(c)(4) Report the results of all investigation is in roorder.  S483.12(c)(4) Report the results of all investigation is in roorder.  S483.12(c)(4) Report the results of all investigation is in roorder.  S483.12(c)(4) Report the results of all investigation is one 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	The state of the resident she and the resident aughed about it and it was a running joke that she would put her hand by the emergency release button.  CFR(s): 483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  S483.12(c)(2) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  S483.12(c)(4) Report the results to fall investigated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the indicate, and if the alleged violation is not must be taken. This REQUIREMENT is not met as evidenced by:  Based on observation, clinical record review, policy review, staff interview, and resident to policy review, staff interview, and resident to the completed and documented from all known withnesses.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		165313	B. WING			C <b>01/31/2023</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 200 16TH AVENUE EAST ALBIA, IA 52531	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		1
F 610 Continued From page 12		e 12 after an allegation of abuse	F 6	10			
	for 1 of 1 residents re	eviewed for an allegation of The facility reported a					
	Findings Include:						
	tool, dated 12/30/22, Resident #4 which in right knee, and chror stated the resident re of 1 staff for persona assistance of 2 staff dressing, and toilet u completely on 1 staff the resident's BIMS (Status) score as 12 c moderately intact cog A Care Plan entry, daresident utilized a houlift) with the assistance Staff I's Employee Pt 2023 documented ship.m. on 1/9/23.	cluded diabetes, pain in the nic pain syndrome. The MDS equired extensive assistance I hygiene, extensive for bed mobility, transfers, se, and depended for bathing. The MDS listed Brief Interview for Mental put of 15, indicating gnition.  ated 5/5/22, stated the yer lift(a type of mechanical per of 2 staff for transfers.  Junch Report for January the worked 6:30 a.m12:00					
	the resident reported	I facility investigation stated that staff dropped her in the emergency release and one					
	Resident #4 stated 2 (CNAs) had her up in aides pulled the eme landed in the recliner	on 1/24/23 at 9:03 a.m., Certified Nursing Assistants the hoyer lift and one of the rgency release and she and it hurt her. During the 4's husband was present		•			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		165313	B, WING			0	C 1/31/2023	
	ROVIDER OR SUPPLIER		<b>.</b>	200 1	EET ADDRESS, CITY, STATE, ZIP CODE 16TH AVENUE EAST 1A, IA 52531			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG	I	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 610	observed this ever aide threatened to transfers and place release. Resident it was funny.  During an observation of the resident was funny.  During an observation of the resident wheelchair (a type of mechan arrived and assists Staff K and Staff F to the electric wheelchair (a type of mechan arrived and assists Staff K and Staff F to the electric wheelchair of the electric wheelchair of the electric wheelchair of the resident would pull it uses it was a transfer of the resident would deweight of the resident would deweight of the resident would not wood buring an intervier F CNA stated sheelchair electric was stated to Staff F to because during a emergency release fell into bed and it resident reported subsequent transfer.	sident #5 stated that he nt and after it happened the do it again during subsequent ed her hand on the emergency #5 stated that the aide thought stion on 1/24/23 at 9:43 a.m., ector of Nursing (DON) and ferred Resident #4 from her into her bed using the EZ Lift ical lift). Staff F CNA then ed with personal cares and then for transferred the resident back elchair using the lift.  W immediately after cares on a.m., Staff F stated that the e was located at the bottom of the lift and in order to utilize it, p. She stated when pulled, the scend and it depended on the lent as to how fast this would ed this feature was not used a leed to use it for example if the	F	610				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		165313	B. WING _		0	C 1/31/2023
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 16TH AVENUE EAST ALBIA, IA 52531			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 610	resident reported this the room to assist wirstated as they were prechanical lift from the Staff I reached down emergency release anything the resident Staff F stated Staff I and was "kind of laughstated that she utilized once with the resider she (Staff I) acted like to "get a rise out of he Staff I that the reside this. Staff F stated it at this was abuse and shout a half an hour Director of Nursing (Alabout the incident.  During an interview of Staff G CNA stated Front like Staff I.  During an interview of Resident #5 confirmed used the emergency He stated he did not spirited" but stated it #4 arrived during the Staff I utilized the emmad and really upset her really mad becaufunny.	to Staff F, Staff I returned to the the transfer. Staff F coulling the resident in the he bed over to the recliner, and put her hand on the and before Staff F could say told Staff I not to touch that then said she wasn't going to shing". Staff F stated Staff I ad the emergency release at and ever since then she was going to do it again er". Staff F stated she told not disliked her because of did not cross her mind that he did not report it but stated later Staff J Assistant DON) came and asked her and 1/25/23 at 10:14 a.m., Resident #4 told her she did not release with Resident #4. Feel like this act was "mean hurt Resident #4. Resident interview and stated when ergency release it made her her. Staff #4 stated it made se Staff I thought it was so	F6	10		
	I stated Resident #4 to another staff member	n 1/26/23 at 2:04 p.m., Staff told her 2 months ago that r utilized the emergency I dropped her into bed. Staff				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		165313	B. WING		C 01/31/2023			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO				
				200 16TH AVENUE EAST				
OAKWOO	D SPECIALTY CARE			ALBIA, IA 52531				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 610	Continued From p	age 15	F 61	o				
	I	I) joked around with everyone						
		ent that she was going to tease						
		stated after the resident told her						
		ne would go in there, she would						
		own to the emergency release						
		not push it. Staff I stated she						
		nergency release button. She						
	stated when she t	eased the resident and did this						
		l say "don't you do that" and						
		augh(Staff I and the resident).	j					
		thought the resident mistakenly						
		r(Staff I) who used the						
	~ *	e but it was not. Staff I stated						
		#5 were some of her favorite						
		cility and that her father used to		·				
		#5. Staff I stated she thought aught Resident #4 on a bad day						
		ould be scared if someone						
		i) in the lift. She stated she						
		of her way to make someone	ļ					
	feel uncomfortable		:					
		"Lifting Machine, Using a						
		ed July of 2017, stated the						
		ocedure was to establish the of safe lifting using a						
		ne policy directed staff to slowly						
		to the receiving surface.						
	lower the resident	to the receiving danage.						
	The facility policy	"Abuse, Neglect, Exploitation						
		tion Prevention Program",						
		I, stated residents had the right				İ		
	•	ouse which included corporal						
	punishment, verb	al abuse, mental abuse, and						
		he policy stated if the alleged						
		n employee or staff member,						
		immediately reassigned to						
		t involve residents. The policy				ĺ		
	defined "abuse" a	is the willful infliction of injury,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING		(X3) DATE SURVEY COMPLETED		
		165313	B. WING_			C /31/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 16TH AVENUE EAST ALBIA, IA 52531		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 610	unreasonable confin punishment with res mental anguish.  During an interview of Director of Nursing(Dinformed a staff member mistreated the staff member to would not want the staff member again.  During an interview of Administrator stated residents with respectives was there for the restanditted to him that release with Resider stated Staff I stated laughed about it and	ee 16 ement, intimidation, or ulting physical harm, pain, or on 1/31/23 at 8:26 a.m., the OON) stated that if a resident ober that another staff the resident, she expected report it immediately and taff member to work with the on 1/31/23 at 1:04 p.m., the he expected staff to treat of and dignity and stated staff idents. He stated Staff I she used the emergency of #4. The Administrator that she and the resident it was a running joke that and by the emergency	F 6			
	S 483.25(i) Respirate tracheostomy care a The facility must ensineeds respiratory care and tracheal sucare, consistent with practice, the compresare plan, the resider and 483.65 of this suthis REQUIREMENT by:  Based on clinical residerations.	nd tracheal suctioning. ure that a resident who re, including tracheostomy ctioning, is provided such professional standards of hensive person-centered nts' goals and preferences,	F6	Plan of Correction:  Staff education provided regard location of Crash Cart (stored by nurses' station in the CNA Roce Staff Education provided regard equipment available to them or cart for suctioning.  Staff education will be completed admitting residents with a track regarding tracheostomy course in Relias with post course test, suctioning competency, trached cleaning, supplies readily avail bedside, humidification system tracheostomy assessments, he extubation and suctioning process.	pehind the m).  ding the higher to recept the designed tracheal costomy able at s, with the minute the designed tracheal costomy able at s, with the minute minute minute the minute min	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING				(X3) DATE SURVEY COMPLETED	
			A. BOILO	NG			?	
		165313	B. WING				31/2023	
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE			
				200	16TH AVENUE EAST			
OAKWOO	DSPECIALTYCARE		}	ALI	BIA, IA 52531			
(X4) ID	SUMMAR	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	NC	(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETION DATE	
F 695	Continued From p	Continued From page 17						
	failed to assure th	at staff provided appropriate		fo	or future emergency situations.			
	tracheostomy care	e to include the assessment of		,	<ul> <li>Staff education provided regardi</li> </ul>	ing		
	respiratory failure	and failed to provide			contacting the on-call nurse with			
	appropriate trainin	ig to nursing staff on			questions on equipment that car	nnot be		
	procedures during			located.				
	(tracheostomy tub		'	<ul> <li>Night nurse will review crash ca checklist and complete nightly.</li> </ul>	rt supplies			
	and suctioning for			checklist and complete nightly.				
		ed in the transport by MedAir to		н	low residents affected & residents	with		
		ced on mechanical ventilation		1	otential of being affected were ide			
		an Immediate Jeopardy to the		ĺR	Residents with tracheostomies who re	eside to		
		d security of the resident. The		0	akwood Specialty Care have the po-	tential to be		
	facility identified a	census of 36 residents.			ffected. Effective 11.19.22 no reside equiring tracheostomy care reside to			
	The State Agency	informed the facility of the			•			
	Immediate Jeopai	rdy (IJ) that began as of July 27,		C	orrective action taken for residen	t(s)		
	2022 on January	26, 2023 at 10:45 A.M. The			ffected: Resident transferred to Albi	a Hospital		
		red the Immediate Jeopardy on		tc	or immediate care.			
	January 26, 2023	through the following actions:		B/	leasures or systemic changes ma	de to		
					nsure this will not recur and affec			
		provided regarding the location		ľ		• • • • • • • • • • • • • • • • • • • •		
		stored behind the nurse's			<ul> <li>Nursing staff will be educated re</li> </ul>	garding		
	station in the CNA		İ		above plan of correction during	orientation		
		provided regarding on the			process.			
	, -	ole to them on the crash cart for			Facility will continue with curren			
	suctioning.	. III be a second standard maior to			correction to complete orientation	n		
		will be completed prior to			checklists upon hire.			
		ts with a tracheostomy tube		P	Planned monitoring of corrective a	ctions to		
		eostomy course assigned in			nsure practice is corrected and w			
		se posttest, tracheal suctioning heostomy cleaning, supplies		o	occur: Routine audits will be conduct	ted to		
				а	ssure ongoing orientation to process	continues		
		at bedside, humidification stomy assessments, how to			and tracheostomy education is provid			
		, and suctioning procedures for			employees. Results of the audits will			
	future emergency				submitted to QAPI for review and add ecommendations.	ngonal		
		regarding contacting the on-call		ļre	вонинениацинь.			
		regarding contacting the on-call lestions on equipment that						
	cannot be located	• •						
		ı. I review crash cartsupply						
	checklist and con							
	⊥ GHEGNIAL AHU CUH	IDIGLG HIMHUY.	1	i			1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		165313	B. WING_			C
NAME OF P	ROVIDER OR SUPPLIER	100010	1 21 77	STREET ADDRESS, CITY, STATE, ZIP CODE		01/31/2023
	D SPECIALTY CARE			200 16TH AVENUE EAST		
				ALBIA, IA 52531		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 695	Continued From page	e 18	F6	s95		
	Measures or systemion this will not recur and	c changes made to ensure affect others:				•
	educated regarding a during orientation pro Facility will continue to correction to complet hire.  Binder including above placed at nurses' stat to assure that new nuagency) are educated. The scope lowered from the survey after ensureducation and their periodic properties.  1. The Quarterly Mini 10/27/22 documented diagnoses including crespiratory failure, training or services.	with current plan of e orientation checklists upon we listed education will be tion with education sign off ursing staff (Facility and d appropriately.  om "J" to "D" at the time of ring the facility implemented olicy and procedures.  mum Data Set (MDS) dated d Resident#12 had the diagnosis of heart failure, scheostomy, obesity and				
	that the resident requibed mobility, dressing persons. Resident #1 Mental Status (BIMS) suggested an intact of the Care Plan dated administer oxygen as as the protocol direct suction as needed and may indicate worseni	ea. The MDS documented ired extensive assist with g and toilet use from 2 2 had a Brief Interview for of 15 out of 15 which cognition.  10/25/22 directed staff to ordered, change the tubing s, provide humidification and and monitor for changes that ng respiratory status and ian. The care plan did not				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		165313	B. WING			C 01/31/2023
	ROVIDER OR SUPPLIER  D SPECIALTY CARE	<u>.                                    </u>	200	REET ADDRESS, CITY, STATE, ZIP CODE D 16TH AVENUE EAST .BIA, IA 52531		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 695	7/24/22, may suction needed every 4 hour meeded every 4 hour The physician order staff to clean trached prn, resident will clea and change oxygen. The physician order staff to fill humidifical water every evening. On 11/19/22 Situation Recommendation (SAM, Staff B, Director change of condition of breath, generalized discoloration, and an consciousness and a pressure 128/88, putemperature 98.9 an recommendation of On 11/19/22 Focuse at 5 PM Staff C, Reg Resident #12 refuse nausea, finger tips of	received by phone on a trach every 4 hours and as its.  received on 7/27/22 directed betomy 1 time a week and an tracheostomy other days, tubing weekly.  received 10/21/22 directed tion chamber with distilled and as needed.  In, Background, Assessment, BAR) documentation at 8:20 of Nursing (DON) revealed a for Resident #12, shortness and weakness, skin a altered level of reported vital signs of Blood ise 75, respiration 20, doxygen saturation 89% with	F 695	DEFICIENCY)	· ?.	
	temperature 97.6, re sound and abdomer physician, no new or offer to go to the hos Document titled Mer	3, pulse 92, respiration 20, esident refused to have lung assessed, notified rder, Resident #12 refused spital during day shift 3 times.  cy Medical Center Final 22 revealed Resident #12				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I PENTIFICATION ALIMPED.		P) MULTIPLE CONSTRUCTION BUILDING		
		165313	B. WING				C /31/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 200 16TH AVENUE EAST ALBIA, IA 52531	DDE	1 017	0112020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD B IE APPROPRI		(X5) COMPLETION DATE
F 695	with a chronic trach Monroe County Em hypoxia (absence of tissues to sustain by and a large amount WBC count 21.1 (no revealed pulmonary bilateral pleural effectissues that line the transported by Airly diagnosis of severe where they remove replaced it, perform procedure that lets and air passages) with both lungs that we Resident #12 was a ventilation and intraction of a ventilator due acquired at the nurs facility would not tai #12 signed a do no Resident #12 was a "she is still young a During an interview E, Licensed Practic worked the evening receive information was sick, a CNA regord for the beach with the hospital. Staff E stakin color to be ash Resident #12 told Sthe hospital. Staff E nebulizer order and	pleostomy was treated in the sergency Room for acute of enough oxygen in the odily functions), was suctioned of tan secretions returned, formal 4.5 - 11), chest x-ray or (lung) congestion with usions (buildup of fluid in the lungs). Resident #12 was led to Mercy Hospital for the hypoxic respiratory failure dot the tracheostomy tube and led a bronchoscopy (at the doctor look at the lungs which revealed thick secretions here removed with suctioning. Diaced on mechanical evenous (IV) antibiotic.  2 AM, a family of Resident #12 was in the intensive care unit to pneumonia that she sing facility and the nursing ke her back unless Resident tresuscitate (DNR) form, and not going to sign a DNR form,	F	695			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		165313	B. WING			01/31/2023		
	ROVIDER OR SUPPLIER  D SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP 200 16TH AVENUE EAST ALBIA, IA 52531	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 695	problem, it was a di notified 911 and the the crash cart to the resident would code nurse and I had not.  During an interview H, RN, stated she could to the hospital and of 11/19/22. Staff H state trach care before we passed on several three to be done, and day staff wouldn't play staff was not re-add other nurses were not at be cleansed that was not re-add other nurses were not at the inner car was to be cleansed that the resident was "She didn't have a she wasn't doing it" know who would play if it came but she had Resident #12 and the state of the state o	E stated, "That was the #1 saster". Staff E stated Staff H physician while she brought proom for fear that the Example. Staff E stated, "I'm an ER	F	695				
		on 1/25/23 at 1:26 PM Staff did suction Resident #12's						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		165313	B. WING				C / <b>31/2023</b>
	ROVIDER ORSUPPLIER				DDRESS, CITY, STATE, ZIP CODE AVENUE EAST  4 52531	017	31/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 695	tracheostomy 1 time, didn't know how to". was to perform her o had not actually seer tracheostomy care, "  During an interview on the seer tracheostomy care, "  During an interview of the seer tracheostomy care, "  During an interview of the seer tracheostomy care, "  During an interview of the seer the seer to the hospital, had or respiratory therapy of the seer the seer to the hospital, had or respiratory therapy of the seer the	Staff N stated Resident #12 wn tracheostomy care and n Resident #12 do her own I wasn't in her room much".  on 1/25/23 at 12:30 PM, Staff stated she had not omy care for Resident #12 ON at this facility and had not ng staff provide care for 8 did not know what was at de for the tracheostomy  on 1/24/23 at 2:55 PM Staff L, she started work at the Resident #12 was transported onversation with the hospital epartment and Resident #12 ng at 10 liters of oxygen and I had asked if Resident #12 wn to 7 or 8 liters of oxygen ot possible at that time. The resation with a female if the facility would take no code status, and the DON I DO Not Resuscitate (DNR) The DON stated she had by about the DNR status and from her or corporate to	F	95			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C			
		165313	B. WING		(	1/31/2023		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  200 16TH AVENUE EAST  ALBIA, IA 52531			222		
(X4) ID PREFIX TAG	(EACH DEFICIE	'STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 695	Continued From p	age 23	F 69	5				
	Oxygen equipment Assessment #2 signature (lack of oxygen) Steps in procedure humidifying jar and that the water bub #11 periodically retaining, reviewed training, reviewed to form the binder with the cart and its content of the binder with th	ne and a supply of suction ploves and flush solution must all times nes #7 listen to lung sounds are #2 clean stoma site with solution, rinse with saline d disinfect stoma with antiseptic ep for each side, air dry, apply						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE COMP	SURVEY PLETED	
		•	7.1. 23.22.			(	c
		165313	B. WING			01/	31/2023
NAME OF P	ROVIDER ORSUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		•
OAKWOO	D SPECIALTY CARE				00 16TH AVENUE EAST ALBIA, IA 52531		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	Regional Director of Cothe care plans for tracinclude detailed director of Cothe care plans for tracinclude detailed director of Cothe care plans for tracinclude detailed director of tracheostomy humidification set up a complete and had decomplete and had decomplete and had decompleted at the nurse solocated in the room cothe station was stocked with suction supplies and solocated on the top of the completed and be capable to care for tracheostomy as there staff and resident to be During an interview/od 3:20 p.m., Staff D Corsuction machine in Ref. #12's name on it. The	cart and its content.  n 1/26/23 at 12:50 PM the Clinical Services stated that cheostomy residents will tions for the nurses.  23 at 12:50 PM the training y care, oxygen and suction set up was scriptive pictures was station. The crash cart connected to the nurse with tracheostomy and the crash cart check off list the crash cart.  n 1/26/23 at 1:46 PM the evaluation of nursing staff I was confident the staff will refuture residents with a e will be a follow up with the sure.  beservation on 1/25/23 at reporate Nurse pointed out a poom 67 which had Resident e suction machine had a pring out of the canister but	F	695			

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Oakwood Specialty Care	pecialty C	are	Northwe	St Respira	orthwest Respiratory Services Facility Census List - 200 16th Ave East Care Initiatives - Albia, IA 52531 (641)-932-7105	Facility wes-Albia	Census IA 52531	s List 641}-932-7105		*0	137	110301
				Facili	Facility Notes: No notes on File	on File						
	ACENSUS 4	ACENSUS >   ARBAU >   B	12 12	** EST #BUL!	12 12	<del></del>	"Verify a	Facility Access Codes: No Codes on File **Verify and update Cylinder Inventory with every delivery to Facility	Codes: No Co	odes on File I every delivery	to Facility	
PATIENT NAME (FIRST LAST) WIDE STREET	#01	RING		EQUIP NODEL	N/S S.V.	HES	DATE	PREVIOUS CORRENT	2001 2001 2001 2001 2001 2001 2001 2001	carpuson, Kay - Lava,	1.02	A TOP CONTRACT
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