

**Department of Inspections and Appeals
Health Facilities Division
Citation**

Number 10176					Report date January 25, 2024
Facility name Odebolt Specialty Care		Survey dates December 27, 2023 - January 4, 2024			
Facility address 801 South Des Moines Street					
City Odebolt					
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date	
58.19(2)g	481—58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules: 58.19(2) Medication and treatment. <i>g.</i> Administration of oxygen (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II)	I	\$8500.00	Upon Receipt	
58.19(2)j	<i>j.</i> Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition. (I, II, III) DESCRIPTION Based on clinical record review, facility policy review, staff, resident, and family interviews, the facility failed to provide adequate oxygen therapy for 1 of 1 resident reviewed (Resident #9). Due to a diagnosis of congestive heart failure and a recent hospital stay that included Resident #9 requiring the use of a ventilator, she required the use of supplemental oxygen. The staff failed to monitor Resident #9 vital signs and the oxygen tank to ensure she received the proper amount of oxygen. When the staff went to help Resident #9 to lunch,				

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	they found her unresponsive with an oxygen saturation of 45% and an empty oxygen tank. While at the hospital, the staff found Resident #9 had anoxic brain injury (a type of brain injury caused by the deprivation of oxygen). The initial hospital transferred Resident #9 by life flight to a larger hospital, where she died a few days after admission. Findings include: Resident #9's Minimum Data Set (MDS) dated 9/25/23, identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS listed Resident #9 as independent with transfers and bed mobility. Resident #9 required limited assistance from one person for dressing, hygiene, and toilet use. Resident #9 used a wheelchair and walker. The MDS included diagnoses of atrial fibrillation (an irregular and often very rapid heart rhythm that can lead to blood clots, stroke, heart failure and other complications), heart failure, hypertension (high blood pressure), diabetes mellitus, and chronic obstructive pulmonary disease (COPD, long-term lung disease). Resident #9 used oxygen therapy and a non-invasive mechanical ventilator (BiPAP/CPAP). The Care Plan included the following Focuses dated: a. 7/22/22 reflected Resident #9 had a history of physical or emotional trauma. The Intervention				

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	directed that Resident #9 deescalated with listening to music, watching television, visiting, and being around peers/family. b. 10/12/22 indicated Resident #9 required assistance with activities of daily living (ADL). The described Resident #9 was dependent on a wheelchair for distance, incontinent of bowel and urine, and ate independently. c. 12/12/23 indicated Resident #9 had an altered respiratory status/difficulty breathing. The Nurses Note dated 12/4/23 at 10:34 AM indicated the medical provider looked at Resident #9's toe and prescribed an antibiotic while at the facility. The Communication - with Physician Note dated 12/6/23 at 8:47 AM, reflected that the facility contacted the physician. After collaboration with the doctor, Resident #9 went to the hospital. The Hospital's Pulmonary Medicine Progress Note dated 12/11/23 showed that the active conditions upon admission included the following; acute hypoxic respiratory failure (Acute respiratory failure happens suddenly. It occurs due to a disease or injury that interferes with the ability of the lungs to deliver oxygen or remove carbon dioxide. In most cases, acute respiratory failure can be fatal if not treated quickly), osteomyelitis (bone infection) of the right foot and 3rd toe amputation. Resident #9				

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	used 3 liters (L) of oxygen to maintain an oxygen saturation (sat) of 91%. She presented to the hospital on 12/6/23 with complaints of a right third toe wound and underwent an amputation. During the procedure, she received Versed (medication used to relax, decrease anxiety, and cause forgetfulness of a surgery/procedure) and fentanyl (an opioid pain medication). Following the procedure, Resident #9 appeared more lethargic and drowsier. The staff started her on a BiPAP machine (a noninvasive machine used to assist with breathing) and received Narcan (opioid reversal medication) without improvement. Resident #9 had some soft blood pressures (low blood pressure, less than 90/60) and received some fluids but her respiratory status continued to worsen. The hospital transferred her to a higher level of care. At that time, the hospital held her diuretics and antihypertensive (medications to decrease blood pressure) medications. The After-Visit Summary dated 12/12/23 detailed a change in her diuretic, furosemide. The new order directed to take furosemide from a once a day scheduled medication to an as needed (PRN) for lower extremity swelling or shortness of breath, only if blood pressure allowed. The SPN - Nursing/Therapy Communication dated 12/12/23 at 2:02 PM reflected Resident #9 readmitted to the nursing home on skilled care with				

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	Physical Therapy (PT) and Occupational Therapy (OT) services. The Nurses Note dated 12/12/23 at 2:57 PM indicated the nurse contacted the physician to clarify Resident #9's wound care. The note lacked additional requests to clarify orders. The SPN - Skilled Evaluation dated 12/13/23 at 7:33 AM reflected that Resident #9 spent most of her day in bed. She frequently used her call light and did very little for herself. She required assistance from two persons with pivot transfers. Resident #9 used 3 L of oxygen continuously by nasal cannula (NC). The oxygen connects to the CPAP machine while in bed. Resident #9 struggled to roll in bed when changing her incontinent pads. The SPN - Skilled Evaluation dated 12/15/23 at 2:21 AM, reflected Resident #9 had unstable oxygen saturations. At the time, Resident #9 always used supplemental oxygen. She used a BiPAP machine at night with oxygen connected. The nurse documented Resident #9's transfers were unsafe, as she refused to stand for transfers, so the staff used a mechanical lift. In addition, she refused to propel herself in her wheelchair to or from meals. All Resident #9 I wanted to lie down and sleep. She showed very low motivation and drowsiness.				

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	The chart lacked documentation of vital signs for 12/15/23. The SPN - Skilled Evaluation Note dated 12/15/23 at 11:00 PM indicated that Resident #9 refused to have vitals assessed. Resident #9 incontinent of urine and does not want to use the toilet. She needed assistance with repositioning herself, she couldn't put on her CPAP mask without assistance. The SPN - Skilled Evaluation Note dated 12/16/23 at 10:25 PM, Resident #9 on continuous oxygen to maintain stats above 90%. The nurse provided additional education regarding safety during transfers. The struck-out Incident, Accident, Unusual Occurrence Note dated 12/17/23 at 4:18 PM labeled as Incorrect Documentation indicated that the nurse and the Certified Nurse Aide (CNA) assisted Resident #9 to transfer from bed to her wheelchair due to urine incontinence. The staff told Resident #9 to pivot her feet to the right so she could sit in the wheelchair. Resident #9 did not complete the turn before attempting to sit. The staff put the wheelchair under her and made her sit on part of the wheelchair seat. Resident #9 would not push off the wheelchair to scoot back in the chair. Resident #9 slid off the wheelchair and staff placed her on the floor on her buttocks. While the nurse got the Hoyer lift and sling to get her off the				

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	floor, Resident #9 laid down completely on the floor and rolled to her stomach. She told the other staff that is how she fell. The assessment revealed no injuries. The nurse notified the doctor and her husband. The SPN - Skilled Evaluation Note dated 12/17/23 at 10:45 PM reflected that as the nurse assessed Resident #9 she removed her CPAP mask and her oxygen went down to 88%. After putting the mask back on, her oxygen level went up to 96%. The CNAs transferred Resident #9 with the full-body mechanical lift due to fall earlier in the day. She doesn't turn easily and the CNAs report that she does minimal effort with helping them with her care. She uses her CPAP machine anytime she is in bed, which is almost all day and night. The Encounter Note on 12/18/23, indicated the Nurse Practitioner saw Resident #9 in bed wearing her CPAP. The note included furosemide 40 mg scheduled once a day in the medication list. The documentation lacked reference to the need for supplemental oxygen. The Behavior Note dated 12/18/23 at 9:56 AM reflected the facility struck out the incident note from 12/17/23 due to the incident resulted from the behavior of Resident #9.				

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	The SPN - Skilled Evaluation Note dated 12/19/23 at 9:21 AM, the staff observed Resident #9 yelling in the hallway for someone to push her to her room. When the nurse asked why she yelled, she told the nurse she couldn't push herself. The nurse reminded her that she needed to work on her strength, this upset Resident #9 who called the nurse a slur. Resident #9 continued to ask for help, even other residents, by pushing her down the hall. The nurse redirected the other residents from her. The SPN - Skilled Evaluation Note dated 12/19/23 at 10:33 PM, listed the vital signs as completed and entered in the vitals tab. The chart lacked vital signs. Resident #9's husband assisted her to eat in the dining room. The note asked if the nurse addressed abnormal vital signs, the answer indicated yes. The Orders - Administration Note dated 12/20/23 at 11:31 AM indicated Resident #9 went to the hospital. Resident #9's clinical record lacked an oxygen saturation from 12/19/23 and 12/20/23 in the vitals record. The Physical Therapy (PT) Treatment Encounter Note dated 12/20/23, indicated Resident #9 complained of fatigue and required max cues for alertness throughout the morning session. The				

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	Response to Session Interventions reflected that Resident #9 required extra time to process new information. The Nurses Note dated 12/20/23 at 11:33 AM, recorded Resident #9's oxygen dropped and her erratic behavior over the previous 2 days. The Nurse Practitioner gave orders to send her to the emergency room (ER) due to her oxygen and history of drug abuse. The nurse called the ER to provide report on Resident #9 and included their suspicion of her drug use because of her behavior and history. Despite Resident #9 receiving 8 L of oxygen by mask, she did not respond appropriately but started to groan. The ED Note Physician dated 12/20/23 reflected that Resident #9 arrived by ambulance to the ER after staff at the nursing home found her unresponsive. They found her around 12:00 PM with an oxygen saturation around 12. The staff did not know how long she went without her oxygen as they found it on the floor. The facility staff put her on 10 L oxygen via a non-rebreather mask, then called the ambulance. The Review of Symptoms described Resident #9 as unresponsive. Her vital signs listed the use of a BiPAP machine with oxygen at 10 L with a FiO2 (estimate of oxygen concentration provided) at 60% with a 97% oxygen saturation. The blood gasses lab result indicated a PCO2 (carbon dioxide pressure in the artery				

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	typically ranges between 35-45) arterial level of 74 at 1:23 PM, 73 at 3:11 PM, and 71 at 5:13 PM, listed as a critical lab result. The remaining results listed high results, except the acid level of 7.29 listed as a low level. The NT-proBNP (lab test to measure fluid levels) reflected a result of 8460, indicating high levels (greater than 900 is a sign of heart failure). Resident #9 received 60 milligrams of intravenous Lasix (medication to cause excretion of excess fluid on the heart). The Nurses Note dated 12/20/23 at 8:43 PM indicated Resident #9's husband called to update the facility on Resident #9. He reported the hospital sent her to a higher level of care hospital by helicopter due to respiratory failure and excessive fluid. The History of Present Illness dated 12/21/23 at 2:56 AM indicated that Resident #9 admitted to the hospital from an outside ER due to a reportedly anoxic brain injury. Resident #9 lived at a nursing home where they described her as altered for the previous 2-3 days with weird facial expression and sometimes responding inappropriately to questions. The nursing home staff found her on 12/20/23 and took her to the outside ER. That ER couldn't do a CT scan (diagnostic test of the brain) due to her size. On her arrival, she was initially unresponsive during the physician's exam, but once			

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	started on BiPaP therapy she could wake to verbal stimulation and answer basic assessment questions. The History and Physical dated 12/22/23 at 4:09 PM reflected Resident #9 admitted to the intensive care unit (ICU) for acute hypoxic respiratory failure on 12/21/23. Due to Resident #9's high oxygen requirement, she didn't qualify for a bronchoscopy (imaging of the lungs). After a discussion with the ICU team, her family decided to transition her to comfort cares on 12/22/23. Resident #9 wished to transfer back to the nursing home in her husband's personal car. However, due to her high oxygen requirements it didn't work for her safety. The Nurses Note dated 12/23/23 at 5:12 AM reflected Resident #9's husband called the facility to report that Resident #9 died approximately a half hour before. On 1/2/24 at 10:48 AM, Staff G, CNA, explained she went to Resident #9's room on 12/20/23 to get her ready for the day. When she entered the room, she saw Resident #9's CPAP on the floor. She didn't know if the night shift did their rounds. She said Resident #9 didn't appear in distress. They got her ready for the day and put her oxygen tank on and took her out to breakfast. She did not remember if she turned the tank on or if Staff Q, CNA, turned it on. She said Resident #9 went to therapy after breakfast and she didn't see her again until they				

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	went back to the room to get her up for lunch. When they entered the room just before lunch, they found Resident #9 lethargic and unresponsive. She said that she wheeled the resident out to the nurses' station and saw her oxygen saturations at 17%. The seat continued to go up and down even after the nurse put her on a new oxygen tank and mask. On 1/2/24 at 11:22 AM, Staff Q recalled helping Staff G with Resident #9 on the morning of 12/20/23. They took her to breakfast with an oxygen tank, she did not check how much the tank had or if it was on. On 1/2/24 at 1:44 PM Staff F, Licensed Practical Nurse (LPN), said the CNA had Resident #9 in her wheelchair when, the CNA told her that Resident #9 did not respond. After she saw the tank empty, Staff F got another tank, put a mask on Resident #9, monitored the oxygen for maybe 10 minutes and it got up in the 80s. She explained she didn't call the doctor for maybe a half an hour afterwards. She reported giving Resident #9 Her medications that morning at the breakfast table but she didn't look at the oxygen tank. On 1/2/24 at 7:47 AM Staff C, Licensed Practical Nurse (LPN), said Resident #9 behaved erratically in the days leading up to 12/20 when she went to the hospital. She couldn't track conversations very well.				

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	She didn't remember taking Resident #9's vitals or if they monitored her weight for fluid retention. On 1/2/24 at 8:51 AM Staff D, LPN, said Resident #9 complained of a lot of pain to the location of her amputated toe leading up to the hospitalization on 12/20/23. Resident #9 used continuous oxygen at 3 L and her saturations dropped when in bed. She recalled being surprised when she came back from the hospital, they discontinued her diuretics, but she did not call for clarification. She felt the PRN Lasix order should have guidelines or parameters. On 1/2/24 at 8:30 AM, the Director of Nursing (DON) said she noticed a change in Resident #9 after her toe amputation, "more quiet". On the morning of 12/20/23, Resident #1 functioned and later in the day she became lethargic. The DON did not know the hospital changed her Lasix order to PRN and thought that they discontinued the order. She said she expected the nurses to check if the supplemental oxygen worked properly while giving medications. She didn't know for sure what kind of education on the use and administration the CNA's had. On 1/2/24 at 11:11 AM, the Physical Therapist (PT) said when Resident #9 did therapy on 12/20/23 she appeared very lethargic and fatigued. He didn't look to see if the oxygen tank was on. He said the			

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	Occupational Therapist (OT) worked with her after he finished, and the OT took her back to her room. On 1/2/24 at 11:20 AM, the OT said that he didn't remember if he took Resident #9 back to her room after therapy on 12/20/23 and he didn't remember looking at her oxygen tank. On 1/3/24 at 8:40 AM, the Nurse Practitioner said she remembered seeing Resident #9 on 12/18/23 while she laid in bed wearing the CPAP. She didn't know of an oxygen order for when Resident #9 left her room and she didn't know that the Lasix order changed from a scheduled medication to a PRN medication after she returned from the hospital. On 1/3/24 at 10:40 AM Staff F, LPN, said that she didn't know about the PRN order for Lasix for Resident #9 but she thought that someone should have clarified the order. She said she expected increased vitals, watch for shortness of breath, and edema. On 1/3/24 at 9:24 AM, Staff I, Registered Nurse (RN), said she did Resident #9's admission when she returned from the hospital on 12/12/23. She did not have an oxygen order, only an order for the BiPAP machine. She made the decision to put oxygen on her wheelchair for Resident #9's comfort after she complained of shortness of breath.			

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	On 1/3/24 at 2:00 Resident #9's husband said that the night before she went to the hospital, he told the nurse on duty that she didn't act right. She didn't talk, just grunted. The nurse told him that she would check into it later. On 1/3/24 at 11:11 AM, Staff K, Regional Director, said they expected the nurses to complete a full set of vital signs once a day when a resident received skilled services. On 1/3/24 at 3:05 PM Staff Q, CNA, said she didn't receive education for the use of oxygen concentrators and tanks. On 1/3/24 at 3:15 PM Staff A, CNA, said she didn't recall getting education on the use of oxygen concentrators and/or tanks. On 1/4/24 at 3:15 PM, Resident #9's physician who cared for her in the hospital on 12/21/23 said that she needed all the support she could get. The fact she went for a period without supplemental oxygen and diuretics complicated her recovery. The Oxygen Administration policy dated, October 2010, listed the guidelines for safe oxygen administration as: a. Verification of the physician's order and review the order for facility protocol for oxygen administration				

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	b. Before administering oxygen and while the resident received oxygen therapy, assess for symptoms of cyanosis (blue tone to skin, indicating low oxygen saturation), hypoxia (low blood oxygen), rapid breathing, rapid pulse, restlessness, confusion, and vital signs. c. Check the mask and tank to ensure they worked and securely fastened. FACILITY RESPONSE				

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Facility Administrator

Date

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	asleep, or the time of day, of the staff did not document the treatment. During an interview with the Wound Center provider, they described her wound as horrible when they saw her at the Wound Center with the original dressing still on. She reported that the wound tunneled (continued under skin unseen) for the full length of her leg. Findings include: Resident #10's Minimum Data Set (MDS) assessment dated 5/3/23 listed an admit date of 4/27/23 from an acute hospital stay. The MDS identified a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. The Clinical Physician's Orders reviewed on 1/3/24 included the following orders: a. Written 4/28/23: Negative pressure wound therapy 125 millimeters of mercury (mm/hg, a unit of measurement) continuous every day shift changed every Tuesday and Friday for right lower extremity abscess. b. Written 4/28/23: Dakin's (an antiseptic/disinfectant) (¼ strength) 0.125%. Apply to the left lower extremity topically every shift related to a cutaneous abscess (boil or painful red bump under the skin due to an infection of hair follicles or in oil glands) to the left lower leg. i. Revised 5/11/23: Clean the wound with ½ hydrogen peroxide/normal saline using a 35				

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	milliliters (ml) syringe. Then rinse with normal saline, pack the wound with Dakin's soaked kerlix (a woven type of rolled gauze) to all wounds. Cover with 4x4 gauze and an ABD (a gauze pad), tape in place every shift for wound care. The SPN - Admit/Re-Admit Note dated 4/27/23 at 5:30 PM indicated that Resident #10 had an abscess to her right front thigh and her left thigh had a dressing in place of a wound vac. The SPN - Skin & Wound Note dated 4/27/23 at 4:25 PM reflected that Resident #10 had a non-pressure wound to her right knee that measured 16.3 centimeters (cm)2 area, length 7.1 cm, width 3.1 cm, depth 4.0 cm, undermining not applicable (NA), and tunneling 5.5 cm. The SPN - Skin & Wound Note dated 4/28/23 at 11:33 AM listed that Resident #10 had an open lesion to her left medial (middle) thigh that measured area 2.2 cm2, length 2.2 cm, width 1.4 cm, depth, undermining, and tunneling NA. Resident #10's May 2023 Medication Administration Record (MAR) lacked signatures for the negative pressure wound therapy dressing change on 5/5/23 and listed a 9, indicating other / see progress notes on 5/16/12. The MAR also lacked signatures for the Dakin's treatment to Resident #10's left lower extremity for the morning				

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	shift on 5/1, 5/2, 5/6, 5/9, 5/10, and no signature on the evening shift of 5/3. The night shift listed a 9 on the 5/2, 5/4, 5/6, 5/7, 5/9, 5/11 - 5/15. The Orders - Administration Note dated 5/5/23 at 6:46 AM indicated that Resident #10 didn't have treatment completed as resident didn't want to do, due to the time of the night. The Clinic's Physician's Order Sheet and Progress Notes from the Wound Clinic dated 5/11/23 listed an order for moist dressing with packing to undermine (damage beneath the skin surface not visible) areas of bilateral medial thighs (inner part of the thigh) daily. The document included the following measurements: a. Right knee area: 6.8 cm x 3.9 cm and depth at 1.8 cm with undermining measurements of 5.4 cm at the 12 o'clock position as well as 4 cm undermining at the 9 o'clock position. b. Left knee open area: 1.4 cm x 1.3 cm, with a depth of 2.5 cm. The area had undermining of 5.2 cm at the 3 o'clock position, 5.2 cm at the 12 o'clock position, 3.7 cm at the 9 o'clock position, and 3.2 cm at the 6 o'clock position. Resident #10's Orders - Administration Notes listed her asleep, indicating Dakins treatment not completed on the following days: 4/30/23, 5/7/23, 5/8/23, 5/13/23, and 5/14/23.				

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	The SPN - Skin & Wound Note dated 5/16/23 at 6:42 AM listed Resident #10's left thigh wound measured length 1.1 cm, width 0.5 cm, depth 1.9 cm, undermining, and tunneling NA. The SPN - Skin & Wound Note dated 5/16/23 at 6:47 AM indicated that Resident #10's right knee measured an area of 13.5 cm², length 7.4 cm, width 2.6 cm, depth 3.5 cm, undermining, and tunneling NA. The Orders - Administration Note dated 5/16/23 at 7:56 AM indicated the facility sent Resident #10's wound vac materials to the Wound Clinic, thus she didn't have treatment completed. Resident #10's clinical record lacked additional measurements between 4/28/23 - 5/11/23, when she went to the Wound Clinic. Her chart lacked an assessments that included measurements until 5/16/23 completed by the facility. On 12/27/23 a Nurse Practitioner (NP) from an outside hospital verified the first time she saw Resident #10 as 5/11/23. The NP described Resident #10's wound as "horrible" with tunneling that went the full length of her leg. The NP explained Resident #10 admitted to the facility with a wound vacuum, and no one changed the dressing. The NP added she knew no one changed it, as the wound vacuum dressing still had the original date				

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	on it. The NP explained she sent Resident #10 directly to the wound clinic for treatment. During an interview 1/3/24 at 9:15 AM with Staff F, Licensed Practical Nurse (LPN), revealed she worked at the facility during the time Resident #10 resided in the facility. Staff F described herself as the second nurse to time and note the wound vac order from 4/28/23. Staff F explained she changed the wound vacuum dressings before, and that she had a little to no training. When asked about the documentation holes in the MARs from May 2023, Staff F reported the staff might have missed the treatments to Resident #10's left lower leg on the mornings of 5/1, 5/2, 5/6, 5/9, and 5/10 and evening shift of 5/3. Staff F explained that if something showed up on the MAR to sign off and the staff hit no then they needed to give a reason why they didn't complete the order. Staff F added that the complete the treatments it auto populates a response in the Electronic Health Record (EHR) progress notes. When asked about the hole in the MAR for 5/5 related to the changing of the wound vacuum, Staff F revealed the wound clinic could have completed the dressing at the wound clinic that day. On 1/3/24 at 9:21 AM Staff I, LPN, revealed she worked at the time Resident #10 lived at the facility. Staff I described herself as the nurse who timed and noted the wound vacuum order from				

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	4/28/23. When asked if she received any training to apply the wound vac dressings, Staff I replied she had little to no training on placing the dressings. Staff I explained she changed the wound vac dressings several times and felt comfortable completing the tasks. When asked about the holes in the MAR from May 2023 Staff I revealed that the treatments to Resident #10's left lower leg could have been missed in the mornings if they were not signed off. Staff I further revealed that if a treatment or medication was out of its timeframe then it would show up in red on the computer, but not for the next shift. On 1/3/24 at 10:15 AM the Administrator revealed she expected the staff to follow physicians' orders as written and for the nurses to chart when completed in the Electronic MAR. On 1/3/24 at 12:05 PM Staff K, Regional Director of Operations, reported the facility followed standard protocols when following physician's orders. Staff K added that she expected the facility follow the orders as well. The facility didn't have a policy to review regarding following physician orders.				

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	FACILITY RESPONSE				

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Facility Administrator

Date