STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165442	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE	1922 FIFTH AVENUE NW WAVERLY, IA 50677

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F 000	INITIAL COMMENTS Correction date 8/31/19 The following deficiencies relate to the investigation of incident #82412 & #83213. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C). Complaint #83482, 83485 & #83629 was not substantiated. The facility took immediate action after incident #83213, therefore the deficiency will be considered past non-compliance. A plan of correction and an onsite revisit is not required for F689.	F 000	F 000 Please accept this plan of correction as the facilities credible allegation of compliance. Please note deficiency for F658 will be corrected by 8/31/2019.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy review and staff interviews, the facility failed to ensure professional staff administered resident medication as directed for one of eight residents reviewed. (Resident #1) The facility census was 98 residents. Findings include: 1. The Minimum Data Set (MDS) assessment documented Resident #1 had diagnoses of Alzheimer dementia and Parkinson and required	F 658	F658 Staff A, LPN was interviewed regarding the incident and placed on suspension during the investigation. Determination was made to terminate Staff A's employment due to inconsistencies in her statements. Staff A failed to appear for scheduled meeting to give her the results of our investigation and term her employment. Staff A also refused to return several phone messages left for her. Staff A was not allowed to work on the floor at any point once the medication error was discovered. Report was also made to the Iowa Board of Nursing. In-Service education was provided to nurses and certified medication aides on the medication administration policy and controlled substance policy on 7/24/2019. Nursing leadership will audit and observe medication pass weekly for continued next page...	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Veronica Shea — TITLE: Administrator — (X6) DATE: 7/31/19

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.

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F 658	Continued From page 1 extensive assistance for transfers, ambulation dressing, hygiene and toileting. The plan of care indicated the resident received anti-anxiety medications and directed staff to use medications as ordered by the physician and monitor for side effects and effectiveness. Progress Notes dated 3/25/19 at 11:26 p.m., revealed the resident received Ativan at 6:30 p.m. Vitals at 10:45 p.m. revealed blood pressure of 92/44 and a heart rate of 86. Staff B rechecked the resident's vitals 15 minutes later to reveal a blood pressure of 60/42 and heart rate of 88. The resident transferred to the emergency room for over night observation. The March 2019 Medication Administration Record (MAR) revealed the resident had an order for Ativan (Lorazepam) 1 milligram two times a day and twice daily as needed for aggressiveness to apply 0.1 milliliter gel to the skin initiated on 3/22/19. The MAR revealed staff administered a total of 6 scheduled doses from 3/23-3/25/19 and one as needed dose on 3/23 at 2:00 a.m. Pharmacy Utilization Record form revealed the facility received 2-1 cc syringes of Lorazepam gel on 3/22/19. The order directed staff to administer 0.1 milliliter/1 milligram topically twice daily and 0.1 milliliters/1 milligram twice daily as need. The form indicated on 3/25/19 at 6:30 p.m. Staff A administered 0.1 (didn't specify milliners) and did not waste any medication. Review of a Medication Error Report dated 3/26/19 revealed the person making the error was Staff A, licensed practical nurse, LPN. The form indicated Staff A gave the wrong dose of	F 658	continued from previous page... one month and then conduct random audits and observations thereafter. This plan of correction will be reviewed at monthly quality assurance meeting until such time as consistent substantial compliance has been met. Newly hired nurses and certified medication aides will be provided with and trained on both the medication administration policy and controlled substance policy during orientation. Nurse managers will ensure competency by observing a med pass before the end of the floor orientation period.	

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F 658	Continued From page 2 medication as she mis-measured the dose. Staff A signed the form on 3/28/19. The form indicated staff gave 10 times more than ordered, gave 1 milliliter instead of 0.1 milliliters. During interview on 7/1/19 at 12:50 p.m., Staff B, LPN indicated Staff A left before the end of shift narcotic count was completed. Staff B and Staff C, LPN completed the narcotic count and noted they were missing 1 full syringe of the Ativan gel. During interview on 7/1/19 at 12:51 p.m., the assistant director of nursing, ADON stated Staff A said she gave the medication but could not remember how much but then stated she administered the syringe then changed her story and stated she gave the correct amount after Staff E told Staff A the correct dose. Staff E stated she felt Staff A made a medication error. Review of the Medication Administration Policy dated 3/17/2011 indicated medication errors, including overdoses or poisoning, will be reported to the attending Physician and medications will be administered in accordance with orders of licensed medical practitioner in the State of Iowa.	F 658		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		

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F 689	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews and observations the facility failed to keep a resident's room free from tripping hazards for 1 of 8 sampled residents (Resident #2). The facility reported a census of 98 residents. Findings include: According to the Minimum Data Set (MDS) dated 4/16/19 Resident #2 had diagnoses which included Chronic Obstructive Pulmonary Disease. The resident had severe cognitive ability and ambulated with limited assistance of 1 staff. Review of the resident's care plan revealed on 4/11/19 she became independent with ambulation in the facility with a 4 wheeled walker and could independently toilet herself. Review of a Fall Scale report dated 4/16/19 revealed the resident had a high risk for falling due to history of falls and weakness. Review of an incident assessment dated 5/4/19 at 4:45 a.m. indicated the staff found the resident laying on her left side with her left arm folded under her. The staff attempted to complete range of motion but unable due to extreme pain. The staff transferred the resident to a local emergency room for assessment of left hip pain The staff indicated their intervention will be to make sure the cord to the air mattress is tucked under the bed to avoid a tripping hazard. Review of the Progress Notes dated 5/4/19 at	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 4 4:45 a.m. revealed a staff entered the resident's room and found her laying on the floor. The resident told the staff she tripped over the cord at the end of her bed and pointed to the cord. The staff noted the resident on her left side with her left arm tucked under her body. The staff assessed the resident who could not move her left leg due to extreme pain. The staff notified the Primary Care Physician and received an order to transfer to a local hospital. Review of a local hospital report dated 5/4/19 revealed the resident entered the emergency room and then admitted to the hospital with a diagnosis of closed displaced intertrochanteric fracture of left femur, septic shock and aspiration pneumonia. Review of a Major Injury Determination form dated 5/4/19, the resident experienced an unwitnessed fall in her room, reported to the staff she tripped over a cord of the air mattress at the bottom of her bed. The physician reviewing the fall determined it a major injury. Review of a facility incident investigation revealed the staff found Resident #2 on the floor in her room on 5/4/19 at 4:45 a.m., the resident reported she tripped over a cord at the end of her bed. Staff F-RN noted an air mattress cord at the foot of the bed upon her investigation. Staff F had maintenance move and secure cords to the bed/mattress out of resident's pathway. Staff F requested maintenance assess all resident's air mattress cords secure them secured to the bed out of the resident's pathways which was completed on 5/4/19. During an interview with Staff G-CMA on 7/1/19 at	F 689		

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F 689	Continued From page 5 6:30 p.m., Staff G indicated she worked the night Resident #2 fell in her room. She stated during last rounds that night the aides went in and saw the resident on the floor. Staff G went to room to assist, upon entering the room she noted the resident had 1 foot tangled in the cord of her air mattress, cursing about the cord. The resident stated to Staff G she tripped over the cord and fell. The resident complained of severe left leg pain. Staff G stayed with the resident until the nurse arrived on the scene. During an interview with Staff H-LPN on 7/3/19, the nurse stated she was called to the resident's room due to a fall. The resident voiced severe pain in her left leg and would not move her leg. The nurse asked the resident how she fell and reported she tripped over the air mattress cord. The nurse call for an ambulance to transport to a local emergency room. During an interview with Staff I-CNA on 7/1/19 at 4:08 p.m. the staff stated it appeared the resident walked between her bed and the wall, tripped over the cord of her air mattress and fell. Staff I summoned the CMA and nurse. The resident voiced pain to her left leg. During an interview with Staff D-DON on 7/1/19 at 5:30 p.m., the DON indicated now the cords to the air mattresses get attached to the bed by maintenance with zip ties. The maintenance staff do weekly or monthly audits to assure compliance with the intervention they put in place. She reported the resident was ill at the time of her fall and passed away the next day at the hospital. During an interview with Staff J-Maintenance Supervisor on 7/1/19 at 7:20 a.m. the Supervisor	F 689		

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F 689	Continued From page 6 stated he received a phone call on 5/4/19 to alert him of the fall of Resident #2 and the cause. It was reported she tripped over the air mattress cord at the end of her bed. Staff J assigned one of his staff to go to the facility that day and assess and secure all air mattress cords in the facility. He states they do monthly safety checks to assure the cords are secure on beds with air mattress. He stated since May 4 they have had to replace 2 zip ties on air mattress cords as they fell off. During a tour of the facility on 7/1/19 at 4:30 p.m. it is noted the facility has 14 residents with air mattresses on their bed, the tour revealed the cords tucked and secured under the resident's beds. Review of a Safe Resident Transfer Procedure dated 2/1/2015, it is the goal of the facility to reduce the potential for injury to residents and if a resident experiences a fall the nurse will assess the resident and if necessary to notify medical personnel.	F 689		