DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2020
FORM APPROVED
OMB NO. 0938-0391

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 08/03/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 DO	INITIAL COMMENTS Corrected date: 8/18/20 A COVID-19 Focused Infection Control Survey was conducted by the Department of Inspection and Appeals on 8/3/20. The facility was found to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total residents: 91 Facility reported incident #91796-I was changed to #91796-M and investigated seperately. Investigation of complaints #90654-C and #89764-C resulted in the following deficiencies.	F 000	Please accept this plan of correction as the facility's credible allegation of compliance. Please note that all alleged deficiencies have been corrected by: August 18, 2020.	
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. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and policy review, the facility failed to ensure adequate supervision to prevent accidents and injuries for 1 of 10 residents reviewed (Resident #8). The facility reported a census of 92 residents.	F 689	Facility immediately initiated disciplinary action against the nurse who left the resident unattended in the restroom. Nurse was provided with re-education from the Staff Development Coordinator. Nurse was required to read the Safe Resident Transfer Policy and verify she understood the policy. All licensed nurses were instructed to carry a resident care sheet and nurse aides were re-educated that a resident care sheet is a required part of their uniform. Audits are performed weekly by asking staff to show nursing leadership their resident care sheet. PIP for fall reduction was initiated on 7/21/2020. Weekly updates on falls to all staff and incidents are reviewed at huddle which includes a comment section for opportunities for improvement in fall reduction. Communication to all staff via huddle sheets regarding Safe Resident Transfer policy was provided on 7/9/2020. Re-education provided on 7/28/2020 about transfers procedures for a resident who has fallen and where staff can locate the Safe Resident Transfer policy in the computer public drive.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Veronica Shea | TITLE: Administrator | (X6) DATE: 9/2/2020

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 689	Continued From page 1	F 689		

The MDS (Minimum Data Set) for Resident #8 with a completion date of 6/2/20 listed diagnoses of depression, glaucoma, weakness and cognitive impairment. The MDS documented the resident needed extensive assistance of one person for transfers, ambulation and toilet use. A (BIMS) Brief Interview for Mental Status score of 3 indicated severe cognitive impairment.

Review of a Progress Note dated 7/1/20 at 4:10 A.M. indicated the resident was found on the bathroom floor after the bathroom call light was activated. A head to toe assessment was completed and the resident was assisted up by 2 staff with a gait belt and a four wheeled walker. Upon ambulating back to bed it was noted that the resident's right foot was turned at a 90 degree angle. The physician was notified and ordered a stat (immediate) x-ray which revealed a displaced oblique fracture of the distal metaphysis of the tibia (large bone in lower leg) and a displaced avulsion fracture of the tip of the medial malleolus (ankle bone).

During an interview with Staff A, Registered Nurse (RN), on 7/30/20 at 5:30 A.M. she reported she walked Resident #8 to the bathroom with Staff B, and then Staff A left the bathroom as she needed to assist another resident in getting ready for dialysis. Staff A reported she did not know if Staff B stayed with Resident #8 or not while she was on the toilet. Staff A reported as she was coming out of the room of the resident she had assisted to get ready for dialysis she was notified by Staff B that Resident #8 had fallen in the bathroom. Staff A reported she did not see it on the aide sheet that Resident #8 was not to be left unattended on the toilet. Staff A acknowledged that the information was on the plan of care and

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F 689	Continued From page 2 the two documents are to match. During an interview with Staff B, Certified Nursing Assistant (CNA), on 7/30/20 at 8:30 A.M., she reported she entered Resident #8's bathroom as the emergency bathroom light was activated. Staff B reported when she entered the bathroom Staff A was assisting Resident #8 onto the toilet. Staff B reported she then left the bathroom after she saw Staff A assisting Resident #8 to the toilet as she had other call lights that needed answered. Staff B reported a short time later she had heard that Resident #8 had fallen in her bathroom. In a phone voice message on 7/3/20 at 12:40 P.M., Staff E, CNA, reported she was returning from her lunch break when she noticed Resident #8's bathroom emergency call light was activated. Staff A went in Resident #8's bathroom to answer the light and that is when she found Resident #8 on the floor. Staff E stated she kept the emergency call light activated in order to get assistance from Staff A and Staff B. Staff B arrived and then went to get Staff A for assistance while Staff E remained with Resident #8. Staff E reported Resident #8 denied pain after Staff A's assessment so Staff A, Staff B and Staff E, proceeded to get Resident #8 up off the floor all together using a gait belt and ambulated her back to her bed. Review of form titled Disciplinary Action signed by Staff A, Staff C and Staff D on 7/2/20, revealed Staff A assisted Resident #8 to the toilet and left the resident alone in the bathroom instructing the resident to activate the call light when she had finished. The form further revealed Resident #8's care plan and aide care sheets stated that	F 689		

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F 689	Continued From page 3 Resident #8 needed supervision while toileting for safety. Review of the care plan directed staff as follows related to impaired mobility from spinal stenosis and impaired vision from glaucoma effective 12/23/19: 1. Please do not leave me unattended in the bathroom. Review of the aide sheet indicated the resident was a fall risk and directed staff to stay within arm's reach while toileting in the bathroom. Review of facility document titled Safe Resident Transfer Procedures with a revision date of 9/18/19 directed staff to use a mechanical lift if a resident falls and they are medically stable yet unable to get off the floor on his/her own, regardless of prior transfer status. Review of the facility document titled Major Injury Determination Form dated 7/1/20 at 1:30 P.M. and signed by the physician revealed after reviewing the circumstances, injury and prognosis of the patient, it was believed the injury sustained is a major injury. During an interview with the DON (Director of Nursing) at 1:10 P.M. on 7/29/20, she indicated it is an expectation for staff to follow a resident's plan of care at all times unless a resident refuses the intervention.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with	F 725		

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F 725	Continued From page 4 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews the facility failed to ensure staff responded and answered resident's call lights in a timely manner to met resident needs for 6 out of 7 residents reviewed. Review of the call light log for the dates of 7/14-7/28/20 revealed 6 out of 7 residents, with a history of falls, that had call lights activated for greater than 15 minutes. There were 59 individual call light events for the 7 residents in that time period.	F 725	Staff education was provided on 7/29/2020 regarding the requirements for call light response time. Nursing leadership is monitoring call light reports and reviewing with floor staff a minimum of three times per week which was initiated on 7/29/2020. After trends of unexpected absenteeism was identified, nursing leadership is reviewing and adjusting staffing levels in anticipation of employee exclusions due to illness.	

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F 725	Continued From page 5 During an interview with 7 residents regarding call lights, Resident #5 reported they are short staffed and they used to forget her in the bathroom after she would turn on the call light. Resident #6 stated she doesn't use her call light during busy times which has become most of the time. During an interview on 7-30-20 at 9:20 A.M. with Amanda Dobbs, Director of Nursing, she stated her expectation for the amount of time for staff to answer a call light is 15 minutes or less. Staff are to check in with the resident and determine if it is an immediate need or whether they can wait, if other call lights are on at the same time. She stated that the staff are to leave the call light on in the room if they are going to leave and come back.	F 725		