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	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Terrace	1922 Fifth Avenue NW Waverly, IA 50677

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35438 Based on observation, staff interviews, record review, and policy review, the facility failed to follow safety interventions for 1 of 3 residents reviewed (Resident #2). On 11/11/24 facility staff failed to position Resident #2's bed in the low position before leaving the resident unattended and alone in the room. The resident had an unwitnessed fall from the bed to the floor which resulted in a fracture of the right femur. The facility identified a census of 86 residents. Findings include: 1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 2, indicating severely impaired cognition. The MDS further indicated Resident #2 had moderately impaired vision, required extensive assistance of two staff for transfer and bed mobility. The MDS included diagnoses of Multiple Sclerosis, Alzheimer's disease, osteoporosis, chronic pain, and muscle weakness. The MDS documented the resident had experienced 1 fall with no injury since admission or reentry. The Care Plan with a target date of 12/14/23, identified a focus area related to fall risk as evidenced by a history of frequent falls, required staff assistance for transfers, and on antidepressant medications. Interventions included: intentional rounds, bolsters added to bed for safety and boundary identification, bright colored tape to call light, call light use reminder sign in room at eye level, push pad call light x2, check the position of pillows used to created borders on each side of the bed during focused rounding, ensure the resident is in a safe position in bed when completing intentional hourly rounds at night, and positioned appropriately and comfortably before leaving room when putting to bed. Review of an undated facility document identified as the Care Sheet for Resident #2 included the following safety directives to be implemented by staff: Assist to bathroom after meals, orange stop sign at eye level as reminder to use call light, intentional hourly rounding, push pad call light x2 on right side of bed, assure good placement before leaving the room, 1 assist pivot transfer to wheelchair, bright colored tape to call light, lift chair unplugged for safety, legally blind, stay with resident when in bathroom, remove clutter from floor, keep items of interest within reach, non-skid footwear when up, bolster with pillow on each side while in bed for boundary identification. In an observation on 4/3/24 at 10:15 a.m., a tour of the facility revealed occupied and unoccupied beds were in a low position. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A facility unwitnessed fall incident report dated 11/11/23 at 11:40 p.m. prepared by Staff A, Registered Nurse (RN) documented that she was called to the residents room, Resident on the floor with a Certified Nursing Assistant (CNA) with resident. CNA reported having responded to the Resident yelling for help. Staff A, RN further documented the bed was not in the lowest position, the call light was not on, and the Residents right leg was distorted and appeared fractured. The Resident was sent to the local emergency room (ER) via ambulance. Review of a local Emergency Department Note with a date of service 11/12/23 included: Right femur fracture with mild displacement and foreshortening. Family declined further referral or treatment. In an interview on 4/3/24 at 4:10 p.m. Staff B, Licensed Practical Nurse (LPN) reported that on 11/11/23 at approximately 8:00 p.m. Staff C, CNA was caring for Resident #2 with the bed in the high position when she entered the room to administer medications. Staff B responded that she left the room prior to Staff C completing care and would not know if Staff C had lowered the bed. The facility provided a written signed statement dated 11/12/23 from Staff C, CNA that included: saw resident last at about 8:00 p.m. with the nurse on duty at that time. Always put the bed up high for good body mechanics. Had provided care and the nurse had given the resident medication. Covered her, put the pillow under her back, call light in place and bed in the lowest position. The facility provided a written signed statement dated 11/12/23, from Staff D, CNA that included: At 11:50 walked into Resident #2's room in response to hearing her yell, Help, Help .I've fallen. Noted the bed was in the highest setting and residents' call button was on the edge of the bed and the covers were folded back. Resident was on the floor laying on her left side with her right leg twisted under her left leg. In an interview on 4/3/24 at 3:19 p.m. Staff A, RN recalled on 11/11/23 had been walking down the hall to give Resident #2's midnight medications when Staff C, CNA reported that Resident #2 was on the floor. Staff A stated that she observed the residents bed was in the highest position, which was a concern, would not expect to leave the bed in the high position for any resident but especially not Resident #2 because of fall risk and poor eyesight. Further stated that the resident's right leg was broken from the fall so transferred to the local emergency room . In an interview on 4/3/24 at 1:50 p.m. the Administrator responded she had completed the investigation into Resident #2's fall and determined that the facility failed to have the residents bed in the low position as would be expected for all residents. The Administrator added that would expect the bed to be in the low position when residents are in bed and unattended by staff. Investigation had revealed the bed had been left in the high position which contributed to the fall with injury. During further interview on 4/3/24 at 3:50 p.m. the Administrator stated she had reviewed the camera footage from 11/11/23 which included the following: 9:34 p.m. Staff C appears to look in room but does not enter 9:45 p.m. Staff D looks in room but does not enter 10:40 p.m. Staff A looks in room but does not enter 11:33 p.m. call light adjacent room comes on, Staff D responds (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	11:34 p.m. Staff D exits adjacent room and enters Resident #2's room 11:37 p.m. Staff C enters Resident #2's room 11:38 p.m. Staff C exits room and returns at 11:39 with Staff A The Administrator further stated the facility had concluded that Resident #2's bed had been left in the high position which contributed to the fall with injury. The facility was unable to provide a policy or protocol that directed positioning of bed when resident in bed and unattended.