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	08/27/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, document review, policy review and staff interview, the facility failed to ensure residents were free from physical abuse when a Certified Nursing Assistant (CNA) tapped a resident on the head during care provision for 1 of 3 residents sampled (Resident #1). The facility identified a census of 87 residents.Findings include:The Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 00/15 indicating severe cognitive loss. Resident #1 exhibited inattention (being easily distractible/having difficulty keeping track of what is said) which was continuously present and disorganized thinking (rambling or irrelevant conversation, illogical flow of ideas, or unpredictable switching from subject to subject) continually present. Resident #1 required moderate/partial assistance (helper does less than half the effort. The helper lifts, holds, or supports the trunk or limbs, but provides less than half the effort) with toileting for occasional incontinence of urine and personal hygiene. The MDS listed diagnoses of mild cognitive impairment of uncertain/unknown etiology, other amnesia, reduced mobility and chronic kidney disease.A Facility Investigation Note submitted to the Iowa Department of Inspection, Appeals and Licensing (DIAL) detailed on 7/02/25 Staff A, Registered Nurse (RN) called to inform Staff B, Director of Nursing (DON) of an allegation of abuse. At 4:30 AM, Staff C, CNA went in to assist Resident #1. Resident #1 became aggressive and started to hit and scratch Staff C. Staff C assisted the resident to sit down on her bed and stepped away to calm herself, then went to get Staff A. Staff A finished assisting Resident #1. Resident #1 was calm and compliant. At 5:45 AM, Staff C reported to Staff A when Resident #1 was aggressive earlier, she got frustrated and tapped Resident #1 on the head. Staff A asked why Staff C hadn't reported it earlier. Staff C responded, she just spaced it out. Staff A informed Staff C that is not appropriate behavior and is abuse. Staff A stated she was aware. An undated Statement from Staff A documented at 5:45 AM Staff C came to Staff A and stated that during rounds a resident became aggressive, hitting and scratching at her. During this time, the staff member (Staff C) became frustrated and without thinking, tapped the resident on the head, sat the resident back down on the bed, stepped away to calm herself, then went to get her (Staff A) for assistance. Staff A requested Staff C write a statement and explain why she hadn't reported the incident at the time of the altercation. Staff C stated, she just spaced it out. When Staff C finished writing her statement, Staff A sent her home. An undated, untimed Statement signed by Staff C, documented Resident #1 was hitting and scratching when she tried to change her brief. Staff C was trying to get the resident to stand up as the resident was hitting. Staff C was blocking the resident and tapped Resident #1 on the head, then sat (kind of guided) the resident back down to the bed, then asked Staff A to help her out. A Disciplinary Notice dated 7/03/25 at 10:00 AM documented on 7/02/25 Staff C reported to the nurse that while she was providing care to a resident, the resident became combative and she tapped the resident on the head. The resident was not injured. Staff C understood is dependent adult abuse and was reportable to DIAL. The Disciplinary Notice documented Staff C was being terminated 7/03/25. Staff C signed the document without dating. The Disciplinary Notice was signed 7/03/25 by Staff B on 7/03/25. A note handwritten on the bottom left corner of the document stated the staff member did not appear remorseful. States she is afraid if it happens again, she might swing on somebody.An 8/25/25 review of Staff C's Employee File revealed a Direct Care Worker (DCW) check showing Staff C with a current CNA certification as of 2/28/25. A Record Check Evaluation prior to employment documented Staff C was arrested and taken into custody on 8/02/23 and charged with a serious misdemeanor conviction for the possession of a controlled substance, marijuana first offense, but was cleared to work as a CNA on 4/17/25. Observation on 8/25/25 at 12:40 PM Resident #1 pushed herself away from the dining room table while seated in her wheelchair. Resident #1 verbalized she needed to, go. Staff D and Staff E, CNA's assisted Resident #1 to walk to the bathroom, toilet and walk back to the lounge. Staff D and E provided Resident #1 with choices, and were patient with care. Observation on 8/25/25 at 1:44 PM Resident #1 sat in the recliner in the lounge with feet elevated. Resident #1 watched other residents and staff with a calm demeanor. An 8/25/25 at 2:07 PM review of the Care Sheet updated 7/29/25, under Behaviors and Preferences lacked documentation Resident #1 had any behaviors or direction to the staff on what to do for behaviors. The Care Sheet only noted Resident #1 could be hard to wake in the morning. Observation on 8/26/25 at 8:04 AM Resident #1 sat in the doorway of her room in the wheelchair and verbalized she was having a good morning. During interview on 8/25/25 at 12:33 PM Staff D explained when a resident has behaviors, they are to leave the

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on clinical record review, policy review, facility investigation review and staff interview the facility failed to complete a thorough investigation after a Certified Nursing Assistant (CNA) reported physical abuse which occurred on the dementia unit affecting 24 of 25 residents (Resident #2, #3,#4, #5, #6, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25 and #26). The facility reported a census of 87 residents.Findings include:A Facility Investigation Note submitted to the Iowa Department of Inspection, Appeals and Licensing (DIAL) detailed on 7/02/25 Staff A, Registered Nurse (RN) called to inform Staff B, Director of Nursing (DON) of an allegation of abuse. At 4: 30 AM, Staff C, Certified Nursing Assistant (CNA) went in to assist Resident #1. Resident #1 became aggressive and started to hit and scratch Staff C. Staff C assisted the resident to sit down on her bed and stepped away to calm herself, then went to get Staff A. Staff A finished assisting Resident #1. Resident #1 was calm and compliant. At 5:45 AM, Staff C reported to Staff A when Resident #1 was aggressive earlier, she got frustrated and tapped Resident #1 on the head. Staff A asked why Staff C hadn't reported it earlier. Staff C responded, she just spaced it out. Staff A informed Staff C that is not appropriate behavior and is abuse. Staff A stated she was aware. The Facility Investigation lacked documentation of resident assessment, or resident and staff interviews regarding abuse. An 8/25/25 Resident Roster review and Brief Interview for Mental Status score review (BIMS is a quick cognitive assessment in a 0-15 scale used in long-term care facilities to assess a resident's cognitive function. The score helps staff to detect early symptoms of cognitive decline. A 13-15 score indicates intact cognition; A 8-12 score indicates a moderate cognitive decline and a score of 7 or less indicates severe cognitive impairment) revealed the following:a. A BIMS score less than 7: Residents #2, #3, #4, #5, #9, #10, #11, #12, #13, #14, #15, #16, #17, #19, #20, #21, #22, #23, #24, #25, #26. b. A BIMS of 8-12: Resident #6, #8, and #18, c. A BIMS of 13-25: Resident #20.Interview completed on 8/25/25 at 3:08 PM Staff K, RN reported in an abuse situation, she would separate the staff member from the resident, question both the resident and the staff member, then call the state hotline number. During an interview on 8/25/25 at 3:13 PM Staff L, Licensed Practical Nurse (LPN)/Health Services Supervisor verbalized in an abuse situation she would ensure the resident's safety, send the staff member involved home, assess the resident head to toe and call the abuse hotline right away, then fill out an incident report with follow-up at 8, 16, and 24 hours. Interview on 8/26/25 at 8:37 AM Staff G, LPN voiced she is the primary day shift nurse on the dementia unit. On 7/02/25 she was told in morning report a CNA had provided care or attempted to provide care to Resident #1. Staff C had tapped Resident #1 somewhere but she didn't know where. The aide came back and reported it to the nurse. Staff G reviewed her documentation and had completed a follow-up assessment and a head injury flowsheet on Resident #1. She was not asked to do any assessment on any other residents in the dementia unit. She didn't believe that any other residents residing on the hallway had any assessment or follow up after the incident. Staff G voiced possibly Residents #3, #6 and #8 might be able to report if something had happened to them, but none of the other residents on the unit could. If an abuse occurred, she would immediately separate the staff member from the resident, do a full head to toe assessment on the resident with a head injury flow sheet if applicable, fill out a skin assessment to check for bruising and any other injuries, call DIAL within two hours, call the Director of Nursing (DON) or the on-call nurse depending on the time of day, fill out an incident report, and notify the physician and the family. In some cases, she may also notify the psychiatric provider. Interview completed on 8/26/25 at 9:05 AM Staff A explained she went down to Resident #1's room, completed a head to toe assessment with a head injury flow sheet assessment, called the doctor and the DON. She reported off to Staff G that morning. Staff A verbalized she did not go do a physical head to toe assessment on any other residents after the incident with Resident #1. Staff A further explained they verbally designate a certain wing for each CNA in the unit when they come on shift for rounds, but if there is a call light or a need the aide may work other hallways/rooms. Staff C worked the A hallway that night. Staff A voiced there were no residents that have the mental capacity to report if something happened to them in the unit. None of the residents have a high enough BIMS (Brief Interview for Mental Status, is a screening tool used in long-term care facilities to assess a resident's cognitive function. The score helps staff to detect early symptoms of cognitive decline) score for that. During an interview on 8/26/25 at 11:31 AM Staff J, DON reported she and Staff B, DON interviewed Staff A and other staff after the incident with Resident #1. When questioned why the facility investigation did not have any documentation of any other staff interviews, Staff J responded they had done a lot of investigations lately, so maybe they didn't talk to the staff. If they would