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	05/30/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907 Based on observations, interviews, and record review, the facility failed to provide weekly assessment and intervention for 1 of 3 pressure ulcers (PU) reviewed (Resident #64). Review of this resident's record revealed that Resident #64 did not have consistent weekly measurements of an unstageable PU on her heel. The facility reported a census of 85 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A MDS dated [DATE], documented that Resident #64 had 1 unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar. A Progress Note dated 3/9/24 at 5:44 a.m., documented Resident #64 reported that her heels felt painful and rated pain at a 5 out of 10. It documented that her left heel had an approximate 1 (centimeter) cm circular dark colored area that was intact. The area was cleansed and triple antibiotic ointment was applied with adhesive bandages. Resident's legs were elevated so that feet were not touching the bed. This resident verbalized reason for elevating her feet off of the bed. A Progress Note (Secure Conversation) dated 3/14/24 at 3:08 p.m., documented a 1 cm x 1 cm deep tissue injury (DTI) to left heel. Skin prep (a liquid that forms a protective layer on skin) was applied to left heel, moon boots (foam padded boot) in place, and air mattress was on bed. This note requested an order for skin prep to left heel daily. The provider answered yes. A Progress Note dated 3/15/24 at 11:36 a.m., documented that there was a new area noted to the left heel. The heel appeared to be a deep tissue pressure injury. The area was deep maroon in color and was not open at this time. The current treatment was to apply skin prep once daily. The current intervention was a heels up cushion. It documented that the provider was notified via secure conversations. A Progress Note (Secure Conversation) dated 4/11/24 at 7:44 p.m., documented the area to left heel remained. The area appeared to be stalled and unchanged over the past few weeks. The area remained unopen. The current treatment was to apply skin prep daily. The current interventions were for soft boots and heels up cushion. This Progress Note requested to discontinue treatment at this time? It documented that staff would monitor with weekly skin assessments and notify if any changes to area. The provider agreed. A Wound Evaluation dated 3/14/24 at 1:09 p.m., documented DTPI that measured 1.33 cm in length and .86 cm in width. The area was documented at .73 cm squared. A Wound Evaluation dated 3/21/24 at 1:16 p.m., documented DTPI that measured 1.17 cm in length and .73 cm in width. The area was documented at .55 cm squared. A Wound Evaluation dated 3/26/24 at 1:09 p.m., documented DTPI that measured .99 cm in length and .67 cm in width. The area was documented at .47 cm squared. A Wound Evaluation dated 4/2/24 at 1:58 p.m., documented DTPI that measured 1.32 cm in length and 1 cm in width. The area was documented at .84 cm squared. A Wound Evaluation dated 4/11/24 at 12:49 p.m., documented DTPI that measured 1.15 cm in length and .81 cm in width. The area was documented at .63 cm squared. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/24 at 10:48 a.m., the Director of Nursing (DON)/Wound Nurse stated that the PU was stalled on the treatment the facility was doing. This DON stated that the provider gave the okay to discontinue the treatment and to have the nurses do a weekly assessment. This DON confirmed that the PU was not healed at the time. She confirmed that there were not weekly measurements of the wound itself nor was there documentation of an assessment for this specific wound on a weekly basis. This DON acknowledged the requirements for assessment and intervention of pressure ulcers were not met for this resident's PU. 5/29/24 at 1:10 p.m., Administrator acknowledged concern with the lack of weekly assessment and measurements for a DTPI. A Wound Treatments policy dated 4/7/22, directed staff that the facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes in treatment. Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates. 2. The following elements are documented as part of a complete wound assessment a. Type of wound (pressure injury, other wounds as deem appropriate, etc.) and anatomical location b. Stage of the wound, if pressure injury (stage 1, 2, 3, 4, deep tissue pressure injury, unstageable pressure injury) or the degree of skin loss in non-pressure (partial or full thickness) c. Measurements: height, width, depth, undermining, tunneling d. Description of wound characteristics: i. Color of the wound bed ii. Type of tissue in the wound bed (i.e., granulation, slough, eschar, epithelium) iii. Condition of the peri-wound skin (dry, intact, cracked, warm, inflamed, macerated) iv. Presence, amount, and characteristics of wound drainage/exudate v. Presence of absence of odor vi. Presence of absence of pain 3. Wound treatments are documented at the time of each treatment. 4. Additional documentation shall include, but is not limited to: a. Date and time of wound management treatments b. Weekly progress towards healing and effectiveness of current interventions c. Presence of pain d. Treatments or interventions e. Notifications to physician and/ or responsible party regarding wound or treatment changes

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 48003 Based on facility record review, staff interview, and policy review, the facility failed to have the minimum required members at the Quality Assessment and Assurance (QAA) meetings to identify issues with respect to which quality assessment and assurance activities were necessary. The facility identified a census of 85 residents. Findings include: Review of the facility QAA sign in sheets revealed the Administrator, Medical Director, Director of Nursing (DON), and at least two other staff were present at the meetings. The Infection Preventionist Nurse was present for only two of the four quarterly meetings. During an interview on 5/30/24 at 9:35 AM, both CO-Directors of Nursing (DON's) reported the facility did not have the Infection Preventionist Nurse attend the past two quarterly QAA meetings. During an interview on 5/30/24 at 9:50 AM, The Administrator acknowledged that the facility did not have a Infection Preventionist at the past two quarterly QAA meetings. Review of the facility's Quality Assurance and Performance Improvement Plan undated revealed the QAA Committee would include the DON, Medical Director, Assistant DON, Infection Preventionist Nurse, Administrator, Staff Development Nurse and Skilled Registered Nurse Coordinator.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48003 Based on observation, staff interview, and policy review the facility failed to perform proper hand hygiene and to follow proper personal protective equipment guidelines to prevent the spread of potential infection and germs during medication administration for 2 of 6 resident reviewed (Residents # 12 and #14). The facility reported a census of 85 residents. Findings include: During an observation on 5/28/23 at 11:05 AM, Staff A, Registered Nurse (RN) without doing hand hygiene gathered her supplies for insulin administration for Resident #12. Staff A wiped the insulin pen with alcohol and applied the needle cap and primed the pen. Staff A then turned the dial of insulin pen to the correct dosage and proceeded to the resident. Staff A then cleansed Resident #12's abdominal site with an alcohol wipe and administered the insulin. Staff A proceeded back to the cart and took the needle cap off and put it in the sharps container then put the insulin back in the cart. Staff A signed the insulin administration on the computer chart. Staff A did not do hand hygiene after administration of insulin at any time. During an observation on 5/29/24 at 8:50 AM, Staff A, RN did hand hygiene and started to gathered her supplies for Resident 14's medication administration. Staff A, RN took nasal spray and oral medications to Resident #14. After Resident #14 took her oral medications, Staff A administered the nasal spray. She did not apply gloves when doing the nasal spray. Staff A put away the nasal spray in the cart then did hand hygiene. During an interview on 5/29/24 at 1:30 PM, Staff A, RN reported she was aware of the concerns during medication administration and should have worn gloves during insulin and nasal spray administration. During an interview on 5/29/24 at 1:50 PM, Staff B, Co-Director of Nursing reported Staff A, RN should have done hand hygiene pre and post insulin administration. Staff A should have worn gloves when giving insulin or nasal spray. Review of the facility policy titled Administration of Injections revised March 2, 2020 directed staff that gloves are required for administering medications that might involve contact with blood or body fluids.