STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165549	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Woods Care Center	Three Pennsylvania Place Ottumwa, IA 52501

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** 35434 Based on clinical record review, policy review, and staff interviews, the facility failed to ensure staff transferred a resident in a safe manner for 1 of 4 residents reviewed for transfer technique (Resident #14). When a staff member assisted Resident #14 to stand from a seated position, she didn't use a gait belt. Resident #14 fell and sustained a wrist fracture and femur (leg bone) fracture. The facility reported a census of 57 residents. Findings include: Resident #14's Minimum Data Set (MDS) assessment dated [DATE], reflected she had a short and long-term memory problem. The cognitive skills for daily decision making indicated Resident #14 had severely impaired decision-making ability. The MDS stated Resident #14 required extensive assistance of 1 staff for transfers, walking, and bathing. The MDS included diagnoses of repeated falls, heart failure, and Alzheimer's disease. The facility Gait Belt Policy, revised 1/4/12, listed purposes of gait belts which included to provide safe transfers for residents and to allow staff to gradually lower a resident to the floor if necessary, reducing the risk of injury. A 4/22/21 Care Plan entry stated Resident #14 required extensive assistance of 1-2 staff to move between surfaces. The Incident/Accident Report dated 9/29/23 reflected Resident #14 left knee gave out, causing her to fall backwards to the floor. The report described her with her leg adducted (in a position toward the center of the body), with a swollen and painful wrist. An undated written statement by Staff B, Certified Nursing Assistant (CNA), stated she assisted Resident #14 with a shower and had her stand at the bar in order to pull up her pants. Resident #14 went down out of the blue and Staff B held her by her underarms hoping she would go down to the floor easier but she still hit the floor pretty hard. Staff B summoned assistance and other staff arrived. A 9/29/23 at 3:50 PM the Nurse's Notes stated Resident #14 sat in front of her wheelchair in a sitting position and complained of right wrist pain and observation revealed swelling and redness in the right wrist and her left leg appeared adducted. The facility transferred Resident #14 out by ambulance. (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 0689 Level of Harm - Actual harm Residents Affected - Few	A 9/29/23 at 4:40 PM the Nurse's Notes stated Resident #14 had a right wrist fracture. A 9/29/23 at 7:30 PM the Nurse's Notes stated Resident #14 had a fracture of the left knee and would transfer to a different hospital. A 9/30/23 Emergency Department (ED) Progress Note stated Resident #14 fell , sustaining a femur fracture and wrist fracture. She required a higher level of care. A Major Injury Determination Form, dated 10/2/23, stated as the CNA put on a brief on Resident #14 as she stood after her shower, her left leg gave out causing her to fall backwards to the floor. Resident #14 previously required the assistance of 1-2 staff members for physical activities of daily living (ADL). A 10/5/23 at 11:13 AM Nurse's Note stated Resident #14 readmitted from the hospital following a fracture of the left femur and fright ulna (wrist bone). Resident #14 had an open reduction and internal fixation (ORIF a type of surgical repair of a broken bone) of the left femur on 10/2/23. A 10/5/23 Care Plan entry stated Resident #14 required total assistance by 2 staff and a mechanical lift to move between surfaces. A 10/17/23 Social Progress Notes entry stated Resident #14 had a significant change due to her decline since her fall. Resident #14 appeared down at times and unsure of why she could not do things she did previously. A Care Plan entry, revised 1/8/24 stated Resident #14 required total assistance of 2 staff with a gait belt On 4/24/24 at 3:18 PM, Staff B CNA stated she assisted Resident #14 with her shower. After the shower she had Resident #14 stand up from the shower chair at a bar on the wall and Resident #14 slipped. Staff B stated she did not have a gait belt on Resident #14 and Resident #14 almost fell on top of her. She stated when Resident #14 fell , she only had a shirt on and that was the only thing she could hold on to. She stated after Resident #14 fell , she began to utilize gait belts in that situation. On 4/24/24 at 3:55 PM, the Director of Nursing (DON) stated Resident #14 required the assistance of 1 2 staff members at the time of the fall and staff should have used a gait belt. On 4/24/24 at 4:05 PM, via phone, Staff C, Licensed Practical Nurse (LPN), stated she did not witness Resident #14's fall but arrived after. She stated just looking at her, she knew she broke something, with her left foot sideways and her other foot vertical. She stated she had staff call 911 and they sent her to the hospital. On 4/24/24 at 3:55 p.m., the Director of Nursing (DON) stated Resident #14 required the assistance of 1 2 staff members at the time of the fall and staff should have used a gait belt. On 4/25/24 at 8:12 AM, Staff D, CNA, stated prior to the fall Resident #14 was an easy assist of 1 staff member and she could easily stand at the bar. Staff D stated after the fall she was more difficult and now required the assistance of 2 staff. Staff D stated if she assisted Resident #14 to stand at the bar, she would absolutely utilize a gait belt. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/25/24 at 8:36 AM, Staff E, CNA, stated if she stood a resident up at the bar in the shower she would always use a gait belt. She stated after the shower, Resident #14's pants were off so there was nothing else to grab on to. In a 4/25/24 at 11:14 AM email, the Administrator stated with regard to the reporting policy for a major injury, the facility referred to the Major Injury Determination Form.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on observation, interview, record review, and the manufacturer insulin packaging insert, the facility failed to prime the insulin pen prior to administration for 1 of 2 residents reviewed for insulin administration (Resident #6). The facility reported a census of 59 residents. Findings include: Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 13, indicating intact cognition. The MDS included a diagnosis of diabetes mellitus (DM). The MDS reflected Resident #6 received insulin injections for 7 out of 7 days. The Care Plan revealed a focus area revised on 1/6/24 for Type II DM. The interventions dated 8/16/22 revealed diabetes medication as ordered by doctor. The Electronic Medical Record (EMR) revealed the following diagnoses: a. Type II DM with moderate nonproliferative diabetic retinopathy (the walls of the blood vessels in the retina weaken) with macular edema (swelling inside the retina), right eye. The EMR revealed the following physician orders: a. ordered 3/1/24 - Insulin Detemir subcutaneous solution - inject 18 unit subcutaneously one time a day During an observation on 4/23/24 at 7:58 AM, Staff A, LPN (Licensed Practical Nurse), prepped Resident #6 Detemir insulin pen for administration. She wiped the hub with alcohol, applied the needle, and turned the insulin pen knob to 18 units. She did not prime the insulin pen prior to turning the knob to 18 units. She then injected the insulin into Resident #6 abdomen. During an interview on 4/23/24 at 12:10 PM, Staff A queried if the insulin pen needed primed prior to administration and she stated sometimes, but sometimes they didn't need to because of the needles they used. Staff A stated she would read the box of the needles and make sure they didn't need to prime the needle. Staff A then stated she messed up and should of primed the needle. During an interview on 4/25/24 at 11:05 AM, the DON (Director of Nursing) queried on the prep prior to administering an insulin pen to a resident and she stated that all insulin pens needed primed to at least 2 units. The Facility Medication Administration Policy (no date identified) did not address the process of insulin pen administration. The Insulin Detemir Package Insert dated 1/17/19 revealed the following information: a. Prepare your pen (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Check your insulin type 2. Attach a new needle 3. Prime your Pen - Turn the dose selector to select 2 units. Press and hold the dose button. Make sure a drop appears.