PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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	INITIAL COMMENTS Correction date 8-17-16 The following deficiencies relate to the facility's annual health survey and investigation of Complaints #60107-C, #59808-C, #59815-C, #59759-C, #59762-C, #60893-C #60894-C, #60449-C, #60440-C and #60741-C, and incident #59919-I completed from 5/11/16-6/23/16. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C)	F 000	Please see attached as this facilities Credible Allegations of compliance	8-17-16
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative	F 157	Please see attached	8-17-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa Fulton	Administrator	8-4-16

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.

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 157	Continued From page 1 or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to notify the family of a change in condition for 1 of 27 current residents reviewed (Resident #10). The facility reported a census of 60 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 5/27/16, listed diagnoses for Resident #10 to include non-Alzheimer's dementia, anxiety disorder, depression, schizophrenia, and diabetes mellitus. According to the MDS the resident required extensive assistance of 1 staff member for dressing, personal hygiene, and bathing, and supervision and set up assistance of 1 staff for eating and toilet use. According to the Incident/Accident Report for Resident #10, dated 6/9/16, the resident was yelling in the room about breathing tx (treatment) and wanting medication and staff attempted to calm resident, red 0.5 cm (centimeter) x 0.5 cm non-raised area to forehead.	F 157	Please see attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 157	Continued From page 2 A Progress Note dated 6/9/16 at 8:49 a.m., stated Resident #10 had a red area on the right side of the forehead. The notes documented the nurse asked the resident how he/she received the area and the resident did not answer the nurse. Review of Progress Notes from 6/9/16-6/12/16 at 5:30 p.m. (when the family inquired with the facility regarding the resident's condition) revealed no mention of the resident having unclear speech and being unsteady. No further measurements were in the resident's record regarding the resident's forehead bruising, other than the 0.5 cm x 0.5 cm measurement. A Progress Note for Resident #10, dated 6/12/16 at 6:39 p.m., stated the family had spoken to the facility regarding the resident having a bruise to the right side of the forehead that had also moved down to the ear. The note stated that the family was also concerned because the resident had garbled speech and was unsteady on his/her feet. The note stated the resident was sent to the emergency room. Emergency department Progress Notes dated 6/12/16 at 8:55 p.m., revealed the resident arrived in the Emergency room and had bruising over the right eye, ear, right chest, and right thigh. During an interview on 6/22/16 at 5:52 a.m., Staff CC, Certified Nurse Aide (CNA), stated she had worked the night shift on 6/8/16 and noticed that Resident #10 was leaning to the side and was very stiff. She stated the resident was having outbursts and had taken the nebulizer and had put it up to his/her face. She stated the resident's speech was garbled and she could not make sense of what he/she was saying. Toward the	F 157	Please see attached	8/17/16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 157	Continued From page 3 end of her shift, she heard the resident in his/her bed yelling. She went in the room and the resident had a "goose egg" about he size of a quarter on his/her forehead. She stated Staff G, Licensed Practical Nurse (LPN) and Staff A, CNA/Certified Medication Assistant (CMA) came down to assess the resident. She stated she thought Staff G and Staff A knew that the resident's speech was garbled. Staff CC stated she then worked the night shift on 6/10/16 and stated the resident's speech was more garbled and he/she hardly had any clear speech. She stated this was strange for the resident. She stated she worked the night shift again on 6/11/16 and that the resident's speech was still garbled. During an interview on 6/22/16 at 6:49 a.m., Staff G, LPN, stated she worked the day shift on 6/9/16. She stated the resident had a red area on the forehead but that she didn't know what happened. She stated the resident had no abnormal speech. Staff G stated she worked again on the day shift of 6/12/16 and that the resident had no abnormal speech on this shift. She stated that the resident's family members came in that day and inquired about the resident's bruising. Staff G stated she went in the resident's room and he/she had bruising on his/her ear and had a "little raised area" on his forehead which was "dime sized". She stated she consulted with the physician and called an ambulance for the resident. During a interview on 6/21/16 at 6:04 p.m., Staff H, Registered Nurse (RN) stated when she worked the night shift on 6/10/16, she did not notice any speech problems. She stated that the week before she had noticed the resident leaning to the left when she took him to his/her doctor's	F 157	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165463	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 157	Continued From page 4 appointment. Staff H stated she worked the night shift on 6/11/16 and described the resident's speech as "a little off but normal" for the resident. During an interview on 6/20/16 at 2:30 p.m., Resident #10's family member stated when he/she went to visit the resident on 6/12/16 at 4:00 p.m., the resident had a "huge bruise" on the right side of his/her forehead and stated the resident's speech was unclear and this was completely unlike the resident. She stated no one at the facility had called her regarding the bruises and the unclear speech. The facility policy, Change in a Resident's Condition or Status, revised April 2014, stated staff should promptly notify the resident's representative of changes in the resident's medical/mental condition and/or status. During an interview on 6/20/16 at 2:30 p.m., Resident #10's spouse stated he/she had spoken to the resident on 6/9/16 and that his/her speech was fine.	F 157	Please see attached	8-17-16
F 167 SS=F	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.	F 167		

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 167	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide the results of the most recent Iowa Department of Inspections and Appeals (DIA) survey and plan of correction and make the results readily accessible for examination. The facility reported a census of 60 residents. Findings include: Observation on 6/20/16 at 9:30 a.m. revealed the facility's survey results book located in a wall hanger near the front door contained the results of an annual survey completed 6/19/14, and the annual inspection by the Fire Marshall's report dated 6/23/14. The results of the last annual survey completed 8/13/15 was not available to residents. Observations throughout the annual survey conducted 6/20/16 through 6/23/16 did not reveal any additional information available in the survey results book. During an interview on 6/23/16 at 9:00 a.m., the Administrator was not aware the required information was not available in the survey results book and inquired how to obtain the required information.	F 167	Please See attached	8-17-16
F 208 SS=D	483.12(d)(1)-(4) PROHIBITING CERTAIN ADMISSION POLICIES The facility must not require residents or potential residents to waive their rights to Medicare or	F 208	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165463	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 208	Continued From page 6 Medicaid; and not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources. In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However, a nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and a nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the	F 208	Please see attached	8.17.16

PRINTED: 06/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 208	Continued From page 7 extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident. States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to follow their Admission Agreement Policy for 1 of 27 current residents reviewed (Resident #1). The facility reported a census of 60 residents. Findings include: Review of Resident #1's face sheet revealed the resident was admitted to the facility on 4/7/16. Review of Resident's #1's records lacked indication an agreement contract completed and signed by the resident. During an interview on 5/25/16, Resident #1 revealed when he/she first admitted the only paper explained and given to him/her for signature was a code status of advance directives (CPR/DNR Status). Resident #1 stated he/she never received or signed an admission contract or did he receive any information including the Residents Bill of Rights. In an interview on 5/25/16 at 11:40 a.m., Staff FF, Registered Nurse, stated they were unable to locate an admission contract for Resident #1 and stated she can't say if the facility ever completed one. In an interview on 5/25/16 at 3:22 p.m., the	F 208	Please see attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 208	Continued From page 8 Administrator stated no admission agreement or admission packet located for Resident #1. The Administrator stated both the Director of Nursing and Administrator are responsible to make sure the admission agreement is completed on new admissions. The Administrator further indicated all residents are to have an admission agreement completed. The 12/2006 Admission Agreement Policy Statement, Policy Interpretation and Implementation, included at the time of admission, the resident (or his/her representative) must sign an Admission Agreement (contract) that outlines the services covered by the basic per diem rate, as well as any additional services requested by the resident that are not covered by the basic per diem rate. A copy of the Admission Agreement will be provided to the resident or his/her representative (sponsor), and a copy will be placed in the resident's file.	F 208	Please see attached	8-17-16
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225		

PRINTED: 06/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 225	Continued From page 9 including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to report an allegation of abuse for 2 of 2 residents involved in a resident to resident altercation (Resident #8 and #21). The facility reported a census of 60 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 5/9/16, listed a diagnosis for Resident #8 of non-Alzheimer's dementia. The MDS stated the resident required the assistance of 1-2 staff for bed mobility, transfers, walking, dressing, eating, toilet use, personal hygiene, and bathing. The MDS stated the resident had continuous	F 225	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 225	Continued From page 10 disorganized thinking and inattention and stated the resident had trouble concentrating on things and was short-tempered nearly every day of the MDS review period. The MDS stated the resident had physical behavioral symptoms directed toward others daily and had verbal behavioral symptoms directed toward others 4-6 days of the week. The MDS listed the resident's cognition as severely impaired. Review of progress notes for Resident #8, dated 5/10/16 at 9:22 a.m., revealed the resident was hitting and punching other residents. Review of Progress Notes for Resident #8, dated 6/18/16 at 6:29 p.m., revealed the resident was aggressive and agitated and was hitting other residents. The facility lacked an incident report for the above occurrences and lacked documentation of the occurrences being reported to the Department of Inspections and Appeals. The care plan for Resident #8, dated 5/10/16, directed staff to call the resident's family to come visit or talk on the phone with the resident when he/she "won't settle". The care plan directed staff to: intervene before agitation escalated, guide the resident away from the source of distress, engage calmly in conversation, and, if the resident's response was aggressive, walk away calmly and approach later. 2. The MDS assessment tool, dated 5/16/16, listed a diagnosis for Resident #21 of non-Alzheimer's dementia. The MDS stated the resident required supervision and setup assistance for bathing and listed the resident's	F 225	Please see attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 225	Continued From page 11 BIMS (Brief Interview for Mental Status) score 14 of 15, indicating intact cognition. Review of an Incident/Accident Report for Resident #8, dated 5/20/16, revealed Resident #21 walked over to Resident #8 and pushed him/her down. The report stated Resident #8 hit the right side corner of his/her mouth but that it was not bleeding and the Resident #8 indicated no signs of pain. The report stated the facility would attempt to keep the residents separated as much as possible. The facility lacked documentation of the occurrence being reported to the Department of Inspections and Appeals. The facility Resident Behavior and Facility Practices - Abuse policy, revised December 2009, directed all suspected violations, including resident to resident abuse should be reported to the State licensing/certification agency within 24 hours. During an interview on 6/22/16 at 4:53 p.m., the Staff FF, Registered Nurse/MDS Coordinator stated anytime a resident to resident altercation occurred, it should be reported to the Department of Inspections and Appeals. During an interview on 6/22/16 at 4:53 p.m., the Director of Nursing stated when a resident to resident altercation occurred, staff should separate the residents, notify the Director of Nursing, and call the State agency within 24 hours. She stated she needed to do some retraining with staff regarding the reporting of altercations.	F 225	Please see attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 246	Continued From page 12	F 246		8-17-16
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to assist residents return from the dining room after meals, failed to assist residents that required meal assistance (Resident's #6 and #7), and failed to assist residents attendance at scheduled medical appointments (Resident's #1, #2 and #12). Twenty-seven current residents were reviewed. The facility reported a census of 60 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool dated 5/6/16 revealed Resident #6 had diagnoses that included non-Alzheimer's dementia, had severe cognitive loss with symptoms of delirium, required extensive assistance by 2 or more staff members for transfers to and from bed or chair, bathing, toileting, dressing and personal hygiene, and supervision with set-up assistance required for eating, and daily verbal behaviors directed at others. Resident #6's weight history revealed:	F 246	Please see attached	8-17-16

PRINTED: 06/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 246	Continued From page 13 January, 2016 168.2 pounds February, 2016 162.0 pounds March, 2016 159.8 pounds April, 2016 155.0 pounds May, 2016 154.8 pounds June, 2016 153.0 pounds Resident #6's nursing care plan included a problem identified as Activities of Daily Living (ADL) self-care performance deficit, with 8/10/16 goal the resident would maintain current level of function in ADL's, and interventions that included: 1. Provide finger foods when the resident has difficulty using utensils. 2. The resident requires supervision/limited assistance by 1 staff to eat. Another nursing care plan problem identified as behavior problem had a 8/10/16 goal that the resident would have fewer episodes of yelling and cursing at staff, with interventions that included: 1. Provide opportunity for positive interaction, attention, stop and talk with the resident when passing by. 2. Intervene as necessary to protect the rights and safety of others. Remove from situation and take to alternate location as needed. 3. Monitor behavior episodes, attempt to determine underlying cause. A 5/12/16 progress note transcribed by the facility's consultant Dietician stated: resident eating in assisted dining room which is more quiet, resident has eaten better in last 3 weeks in that environment, 90 day weight loss of 7.8 percent, weight loss began when resident moved from the assisted dining room to the main dining room. Recommended resident to continue eating in the assisted dining room and laboratory work	F 246	Please see attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 246	Continued From page 14 that included a complete medical profile and pre-albumin. The note was sent to the physician via facsimile (fax). The physician confirmed the order with signature and returned the document by fax on 5/17/16. Observations of the resident revealed: 6/21/16 at 7:55 a.m., seated in the main dining room, without food or beverages. 6/21/16 at 8:34 a.m., seated in the main dining room, silverware wrapped in a napkin, breakfast in front of the resident that included a bowl of hot cereal, toast, 2 slices of bacon and scrambled eggs, uneaten. 6/21/16 at 8:43 a.m., remained seated at the main dining room table, slumped forward with eyes closed, silverware remained wrapped in a napkin, had not eaten any food presented and no assistance by staff. Continuous observation in the dining room on 6/21/16 between 8:52 a.m. and 10:14 a.m. revealed the resident remained slumped forward in the chair at the table, silverware wrapped in a napkin, no assistance by staff, uneaten food and dishes removed from the table at 9:12 a.m. The resident remained in the dining room chair, without any intervention by staff, until 10:14 a.m. when the nurse practitioner asked Staff S, Certified Nurse Aide (CNA), to assist her to take the resident to their room. Observation on 6/24/16 at 8:20 a.m. revealed the resident seated in the main dining room and the last of those seated that received breakfast. Dietary staff delivered the meal and did not	F 246	Please See attached	8-17-16

PRINTED: 09/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 246	Continued From page 15 provide set-up assistance for the resident, CNAs were not located in the dining room. Observation on 6/24/16 at 8:42 a.m. revealed the resident remained seated in the dining room, silverware remained wrapped in a napkin and the resident had not eaten any of the food presented. Observation on 6/24/16 at 8:52 a.m. revealed the resident remained seated in the dining room without assistance, silverware wrapped in a napkin, the resident had not eaten as the dietary staff cleared the tables. During initial resident tour on 6/20/16 at 10:05 a.m., the Director of Nursing (DON) stated the resident yelled when in crowds and staff required to redirect the resident to a quiet area to reduce the resident's behaviors. During an interview on 6/22/16 at 2:50 p.m., the Dietician stated Resident #6 required assistance to eat, tables on the west side of the main dining room were designated for residents that required meal assistance when the assisted dining room was closed and staff should continue to provide feeding assistance as needed to the resident at meal-time in the main dining room if the assisted dining room was closed. 2. Observation on 6/21/16 in the main dining room revealed: 7:55 a.m. - Resident #6 seated with approximately 30 other seated residents for the breakfast meal. 8:34 a.m. - Resident #6 and Resident #7 seated	F 246	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 246	Continued From page 16 with approximately 40 residents for the breakfast meal. 8:43 a.m. - Resident #6 and Resident #7 remained in the dining room with approximately 35 residents for the breakfast meal. A continuous observation in the dining room on 6/21/16 between 8:52 a.m. and 11:09 a.m. revealed: Resident #6 remained seated in a regular chair until 10:14 a.m. when the nurse practitioner asked Staff S, CNA, for assistance to transfer the resident to his/her room for assessment. Resident #7 remained seated in his/her wheel chair at the table until 10:11 a.m. when the occupational therapy assistant and physical therapist assisted the resident to stand, then ambulated the resident out of the dining room. Another resident seated on the west side of the dining room and present at the 7:55 a.m. observation remained at the same location until Staff S, CNA, assisted the resident with ambulation and return from the dining room at 9:47 a.m. Another resident seated in a wheel chair on the north side of the dining room at the 7:55 a.m. observation remained at the same location until Staff S, CNA and Staff M, CNA, assisted the resident to leave the dining room at 9:53 a.m. Activities were not offered in the dining room throughout the observation. Staff M, CNA, assigned to the 100 and 200 halls,	F 246	Please see attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 246	Continued From page 17 Staff N, CNA assigned to the Memory Care unit, and Staff DD, CNA assigned to the 300, 500 and 600 halls were the only CNAs scheduled for the 6:00 a.m. to 2:00 p.m. shift and on duty on 6/21/16. Staff W, Certified Medication Aide (CMA)/CNA, was assigned as a CMA at Station 1 (100 and 200 halls), and Staff R, CMA/CNA functioned as a CNA when observed on the 100 hall between 6:00 a.m. and 6:45 a.m., then assigned as the CMA for Station 2 (300, 500 and 600 halls) after 7:00 a.m. Staff S, CNA scheduled for the evening shift (2:00 p.m. to 10:00 p.m.) was observed in the dining room at 9:47 a.m. The Director of Nursing (DON) stated Staff S was called in early to work and would stay until 10:00 p.m. The only other nursing staff in the building at that time (other than the DON and MDS coordinator nurse) was Staff G, LPN, who functioned as the nurse on duty for all facility residents. 3. During the group resident interview on 6/21/16 at 1:48 p.m. 3 of 6 residents reported that some of their appointments had been canceled either because the facility did not have a CNA to go with them, or the sister facility had the van. 4. The MDS dated 4/14/16 for Resident#1 documented the resident intact memory. The MDS revealed the resident required extensive assistance of two staff members for bathing, and had bilateral lower extremity weakness. The MDS	F 246	Please see attached	8-12-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 246	Continued From page 18 documented that the resident had Parkinson's disease, a seizure disorder, and heart failure. During an interview on 6/21/16 at 7:30 a.m. the resident reported that he/she had an appointment set up two months in advanced to get a botox injection for his/her chronic pain, and the facility knew about it. The resident reported that he/she missed out on the appointment, because the facility did not arrange the transportation. The resident reported that the appointment had been reschedule for 6/29/16, the doctors office had not been very happy. A Doctors Progress Note dated 4/28/16 documented the resident had worsening symptoms of back pain secondary to spinal stenosis. A small increase in the resident's as needed Percocet 1-2 tablets every 6 hours as needed. The resident does have a pain specialist which he will be seeing in early June. The majority of the resident's chronic pain regimen and medications will be deferred to him. A Doctors Progress Note dated 6/2/16 documented the resident had significant back pain with his/her spinal stenosis and the doctor discussed increasing the resident's Percocet to one tablet every four hours as needed. A Medical Doctor/Nursing Communications form dated 6/21/16 directed the facility staff to make sure that the pain clinic appointment is kept. 5. The MDS dated 5/5/16 for Resident #2 documented the resident with intact cognition. The MDS revealed that the resident required extensive assistance of one person for bathing. The MDS documented the resident had	F 246	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 246	Continued From page 19 diagnoses including peripheral vascular disease, and diabetes, and chronic pain. The MDS indicated the resident had an unhealed pressure ulcer. A Progress Note dated 6/3/16 documented that the resident needed a repeat vascular surgery follow-up and evaluation due to the severity of the resident's history of known peripheral vascular disease in the face of ongoing problems with chronic ulcers to both lower extremities. The progress note documented that the doctor placed a referral to vascular surgery as the resident is overdue for vascular surgery follow-up with the vascular surgery team. The doctor documented that the resident had previously been followed by the vascular surgery. The resident needs this arranged as soon as possible as the resident is known to have extensive peripheral vascular disease along with extensive venous thrombosis (blood clot history). During an interview on 6/22/16 at 4:15 p.m. the clinic Registered Nurse (RN) reported the resident's clinic record lacked documentation the resident had been seen for the revascularization surgery. The clinic RN reported if the resident had been seen at the hospital clinic, there would have been a report in his/her chart. Staff reported that revascularization would help the resident's pressure ulcers heal. During an interview on 6/23/16 at 6:45 a.m. the resident reported that he/she had not been to the hospital clinic for the vascular follow up, the appointment had been canceled by the facility, and needed to be rescheduled. The resident reported that she/he was not sure if the appointment had been rescheduled yet.	F 246	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 246	Continued From page 20 6. The Annual MDS dated 3/2/16 for Resident#12 documented the resident with intact cognition. The MDS revealed that the resident had diagnoses including anemia, coronary artery disease, and ascorbic acid deficiency. During an interview on 6/22/16 at 9:45 a.m. the resident reported that he/she was suppose to have an appointment with a specialist to check out his/her numbness in the legs, that was to be arranged by the facility a month ago. The resident reported that his/her legs are very painful. The resident reported that his/her general practitioner had called to schedule the referral after the last appointment when the general practitioner discovered the resident not seen by the specialist. A Medical Doctor/Nursing Communications form dated 3/28/16 directed the nursing staff to make a neurologist referral appointment for the resident's lower extremity neuropathy. A Medical Doctor/Nursing Communication form dated 6/09/16 documented that the resident still needed a neurologist referral appointment due to increased numbness and tingling in both the lower extremities. The form directed staff that the appointment had been made for 6/20/16, and then to follow up with the residents general practitioner on 7/7/16.	F 246	Please See attached	8-17-16
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings	F 252	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 252	Continued From page 21 to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and resident interviews, the facility failed to maintain a clean, comfortable, homelike environment for 1 of 27 current residents reviewed (Resident #1). The facility reported a census of 60 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 4/14/16 identified Resident #1's diagnoses included non-Alzheimer's dementia, seizure disorder and Parkinson's disease. The MDS revealed the resident with a BIMS (Brief Interview for Mental Status) score of 15 of 15, indicating the resident with intact cognition. The MDS identified the resident required limited assist of one staff member for bed mobility ambulation in room, and dressing. Observation on 5/20/16 at 10:10 a.m. revealed Resident #1's room trash bin with the lid not able to close due to over flow of trash that included soiled incontinent briefs. A strong smell of urine noted in the room. In an interview on 5/20/16 at 10:10 a.m., Resident #1 stated he/she has asked staff for 3 days to have the trash removed from the room but to no one is available. Resident stated the trash contains his/her soiled incontinent briefs in it and it bothers him/her.	F 252	Please see attached	8-17-16
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253	Please see attached	8-17-16

PRINTED: 06/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 253	Continued From page 22 The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interviews, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, odor-free and comfortable interior. The facility reported a census of 60 residents. Findings include: Observations throughout the annual survey and during the environmental tour conducted on 6/23/16 between 8:45 a.m. and 10:22 a.m. revealed: 1. The light golden brown colored laminate floor in the dining room with numerous deep, long, dark-colored linear scratches throughout the dining room and visible from 4 to 5 feet away 2. Dark colored residue and a heavy accumulation of dirt covered the wall surface approximately 2 inches high, and the length of the west and north walls below the wall mounted heating vent in the Assisted Dining Room. The dark color was visible at least 20 feet away from the 100 hall. 3. Two areas of visible water damage on ceiling tiles in the 300 hall soiled utility room. One area measured approximately 36 inches long by 12 inches wide, and the other area measured approximately 48 inches long by 24 inches wide	F 253	Please See attached	8-12-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 253	Continued From page 23 with an approximate 8 inch circular shaped, dark blackish-green colored area of mold-like appearance inside the water damaged area and less than 20 inches away from the common wall shared by an occupied resident room (Room #300). 4. Walls across from the Station 2 nurses station covered with wall paper on the lower approximate 36 inches. One area at the corner had 2 dark brown colored stains of unknown origin that measured approximately 10 inches by 10 inches and 6 inches by 3 inches. Another wall had a linear bulged area approximately 10 feet long along the lower 15 inches of the wall and appeared to indicate water damage beneath the surface. The boiler room was located on the opposite side of the wall. The bulged area was hard when touched. 5. A fenced courtyard area outside with flower beds along the north and east walls, approximately 1/3 weed-filled, with heights of 20 to 36 inches. The flower beds were approximately 36 inches wide, one was approximately 40 feet long and the other approximately 12 feet long. A triangular shaped raised flower bed in the middle of the area also contained weeds. During an interview at that time, the maintenance supervisor stated weed control was recreational therapy for one of the residents and no staff were specifically assigned to care for the gardens. 6. The exterior of the door to the courtyard had rust that covered approximately 1/4 surface of the door. 7. Three electrical wires approximately 10 inches	F 253	Please See attached	8-12-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 253	Continued From page 24 long stuck out of the exterior wall near the courtyard door. The maintenance supervisor stated they remained from a previous doorbell location and could be removed. 8. The hallway walls inside the Memory Care unit near the entrance doors had 5 holes on each wall (2 walls) where alarm panels that monitored the Wanderguard system were removed. Four of the holes measured approximately 3/4 inches across and the 5th hole was over an inch in diameter. The maintenance supervisor stated maintenance staff could repair and refinish the wall surfaces. The Memory Care unit was occupied by 7 residents throughout the survey. 9. Resident rooms 308, 310, 311, 312, 600, 602, 603, 604, 605, 606, 607, 609 and 611 had carpeted floors, most with unsightly stains visible from the hall. Room #300 had a circular stain approximately 15 inches across. Room #601 had an irregular shaped stain located near the foot of the bed and approximately 5 feet from the threshold of the room that measured approximately 24 inches by 18 inches. Room 605 had a stain approximately 20 inches by 12 inches, located in the center of the room and visible from the hall. Room #607 had a stain that measured 18 inches by 21 inches in the middle of the room near the bed. 10. A strong urine odor permeated the hall near resident rooms #604, #606 and #611 throughout the survey. During an interview at that time, the Administrator stated that residents would be moved to one side of the building to consolidate staff resources and would enable required repairs and remodel projects. The maintenance supervisor stated that the urine odor would follow	F 253	Please see attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 253	Continued From page 25 the source when relocated, and the facility has an extractor to remove carpet stains and would be removed in room order. The maintenance supervisor stated during the environmental tour that maintenance staff had started wall paper removal in the 200 hall, would resurface the walls as required and then paint, all walls in the facility would receive the same treatment with no planned date of completion. 11. The Minimum Data Set (MDS) assessment tool, dated 5/9/16, listed a diagnosis for Resident #8 of non-Alzheimer's dementia. The MDS stated the resident required the assistance of 1-2 staff for bed mobility, transfers, walking, dressing, eating, toilet use, personal hygiene, and bathing. The MDS listed the resident's cognition as severely impaired. During an observation on 6/21/16 at 8:54 a.m., Resident #8's toilet had black drips covering the base and the rim of the bowl. 12. The MDS dated 5/12/16, listed diagnoses for Resident #9 of cerebrovascular accident (stroke) and diabetes mellitus. The MDS indicated the resident required extensive assistance of 2 staff for bed mobility, dressing, and personal hygiene, and totally depended on 2 staff for transfers, toilet use, and bathing. The MDS listed the resident's BIMS (Brief Interview for Mental Status) score as 9 out of 15, indicating moderately impaired cognition.	F 253	Please see attached	8-12-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 253	Continued From page 26 During an observation on 6/21/16 at 6:34 a.m., the floor in the resident's room was sticky feeling and food crumbs were present around and under the resident's bed. 13. Observations of the facility shower rooms revealed the following: a. During an observation of the the 100 Hall shower room on 6/21/16 at 6:54 a.m., the shower had orange and black substances on the tile. Thick dust particles hung down from the vent. The grout in between the shower tiles was covered with a black substance. b. During an observation of the 500 Hall shower room on 6/21/16 at 6:58 a.m., the shower floor was covered with a rust-like orange substance. The non-slip pads on the bottom of the shower were coming up and missing pieces. The rubber mat in front of the shower was discolored a dingy brown. c. During an observation of the 600 Hall shower room on 6/21/16 at 7:05 a.m., the grout in between the shower tiles were covered with orange and black substances. The wall of the shower was covered with an orange substance and the baseboard near the shower had an orange substance coming out of the sides. The undated facility Environmental Cleaning Policy stated that the resident care environment throughout the facility would be maintained in a state of cleanliness that met professional standards. During an interview on 6/23/16 at approximately 11:49 a.m., the Administrator acknowledged the condition of the facility was a concern. She	F 253	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 253	Continued From page 27 stated she had had a meeting with the housekeeping and maintenance staff and indicated the problem would be addressed.	F 253	Please See attached	8-17-16
F 254 SS=D	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observations and resident interviews, the facility failed to provide washcloths and towels for 2 of 27 current residents reviewed (Resident #1 and #3). The facility identified a census of 60 residents. Findings include: 1. The Minimum Data Set (MDS) dated 4/14/16, identified Resident #1 diagnoses included non-Alzheimer's dementia and Parkinson's disease. The MDS revealed the resident with a BIMS (Brief Interview for Mental Status) score of 15 of 15, indicating the resident with no short or long term memory problems and no problems with cognitive skills for daily decision making skills. The MDS identified the resident required limited assist of one staff member for personal hygiene. Observation on 5/13/16 at 12:30 p.m. revealed Resident #1's room had no towels or washcloths available. Interview on 5/13/16 at 12:30 p.m., Resident #1 stated there is never any clean towels or	F 254	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 254	Continued From page 28 washcloths in the room. The resident has to get them every day from the selves. If they are available, they are never passed out to residents for use in room. 2. The MDS dated 4/01/16 identified Resident #3's diagnoses included Parkinson's disease and diabetes mellitus. The MDS revealed the resident with a BIMS score of 14 out of 15, indicating the resident with no short or long term memory problems and no problems with cognitive skills for daily decision making skills. The MDS identified the resident required supervision and setup assist of one staff for dressing, eating, and personal hygiene. Observation on 5/20/16 at 7:50 a.m. revealed Resident #3 having no washcloths or towels in the residents room. When interview on 5/20/16 at 7:50 a.m., Resident #3 stated towels and washcloths are never passed out to use in their room. Resident #3 stated he/she will go and get them from staff and at times there are none available.	F 254	Please See attached	8-17-16
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	Please See attached	8-17-16

PRINTED: 06/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 279	Continued From page 29 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, the facility failed to follow comprehensive care plans for 3 of 27 current residents reviewed (Residents #4, #6, #7). The facility reported a census of 60 residents. Findings include: 1. According to the 3/10/16 Minimum Data Set (MDS) assessment, Resident #4 had moderately impaired cognition, and required supervision while eating. The resident's diagnoses included non-Alzheimer's dementia, a seizure disorder and diabetes mellitus. Review of current care plan revealed a focus area of the resident had a swallowing problem related to eating food too fast. The care plan interventions directed staff to make sure the resident alternated small bites and sips, used a teaspoon for eating, don't use straws. The staff were directed to instruct the resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly. The staff were directed to monitor/document/report as needed any signs or symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears	F 279	Please See attached	8-12-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 279	Continued From page 30 concerned during meals. The care plan also revealed a focus: obese resident receives regular diet in her/his room on paper plates due to history of emesis on plate due to increase rate of eating per staff report. The Care Plan directed staff to monitor and document signs or symptoms of dysphagia. The Care Plan directed staff to provide, serve regular diet as ordered in room. The Care Plan directed staff to serve food on paper plates. Record review of Diet/Swallow Recommendation dated 2/25/16 from the Speech Language Pathologist revealed: resident to sit upright at 90 degrees, food to be no larger than ¼ teaspoon per bite, alternate liquids with other foods. Record review of progress noted dated 3/1/7/16 from the Dietician: ST (speech therapy) has assessed resident due to emesis episodes. Recommendations for general diet with thin liquids, no more than ½ teaspoon of food at a time, alternate with solids and liquids and site up right. The Speech Therapist treatment notes included: 2/24/16-Resident seen for skilled speech therapy (ST) treatment to address concern with aspiration. Resident continued ST therapy through 3/7/16 when discharge recommendations discussed with resident and/or caregivers include use of safe swallow strategies to complete meals in a safe and timely manner. Caregivers educated on the importance of use of alternate sip and bite with chin tuck, 90 degrees position and water swish to decrease risk of choking/aspiration with PO intake. Interview on 6/22/16 at 9:50 am with the Staff Development Coordinator revealed CNA task sheets for each resident tell staff how to care for the residents but are more than likely not updated. The Staff Development Coordinator	F 279	Please See attached	8-12-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 279	Continued From page 31 went to obtain the task sheets in Hall 1 but there were no sheets. Hall 2 contained only task sheets for 2 residents. 2. The MDS dated 5/6/16 revealed Resident #6 had diagnoses that included non-Alzheimer's dementia, had severe cognitive impairment with symptoms of delirium, required extensive assistance by 2 or more staff members for transfers to and from bed or chair, bathing, toileting, dressing and personal hygiene, and supervision with set-up assistance required for eating. Resident #6's nursing care plan included a problem identified as Activities of Daily Living (ADL) self-care performance deficit, with 8/10/16 goal the resident would maintain current level of function in ADL's, and interventions that included: 1. Provide finger foods when the resident has difficulty using utensils. 2. The resident requires supervision/limited assistance by 1 staff to eat. A 5/12/16 progress note transcribed by the facility Dietician stated: resident eating in assisted dining room which is more quiet, resident has eaten better in last 3 weeks in that environment, 90 day weight loss of 7.8 percent, weight loss began when resident moved from the assisted dining room to the main dining room. Recommended resident to continue eating in the assisted dining room and laboratory work that included a complete medical profile and pre-albumin. The note was sent to the physician by facsimile (fax), the physician confirmed the order with signature and returned the faxed document on 5/17/16. Observations of the resident revealed:	F 279	Please see attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 279	Continued From page 32 6/21/16 at 7:55 a.m., seated in the main dining room, without food or beverages. 6/21/16 at 8:34 a.m., seated in the main dining room, silverware wrapped in a napkin, breakfast in front of the resident that included a bowl of hot cereal, toast, 2 slices of bacon and scrambled eggs, uneaten. 6/21/16 at 8:43 a.m., remained seated at the main dining room table, slumped forward with eyes closed, silverware remain wrapped in a napkin, had not eaten any food presented and no assistance by staff. Continuous observation on 6/21/16 between 8:52 a.m. and 10:14 a.m. revealed the resident remained slumped forward in the chair at the dining room table, silverware wrapped in a napkin, no assistance by staff, uneaten food and dishes removed from the table at 9:12 a.m. The resident remained in the dining room chair until 10:14 a.m. when the nurse practitioner asked a Certified Nurse Aide (CNA) to assist her to take the resident to their room. Observation on 6/24/16 at 8:20 a.m. revealed the resident seated in the main dining room and the last of those seated that received breakfast. Dietary staff delivered the meal and did not provide set-up assistance for the resident, CNAs were not in the dining room. Observation on 6/24/16 at 8:40 a.m. revealed the resident remained seated in the dining room, silverware remained wrapped in a napkin and the resident had not eaten any of the food presented. Observation on 6/24/16 at 8:52 a.m. revealed the resident remained seated in the dining room without assistance, silverware wrapped in a	F 279	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 279	Continued From page 33 napkin, the resident had not eaten as the dietary staff cleared the tables. During initial resident tour on 6/20/16 at 10:05 a.m., the Director of Nursing (DON) stated the resident yelled when in crowds and staff required to redirect the resident to their room where it was quiet in order for the behaviors to stop. During an interview on 6/22/16 at 2:50 p.m., the Dietician stated the resident required assistance to eat and if the facility had closed the assisted dining room that staff should continue to provide assistance as needed to the resident at meal-time. 3. Resident #7 had a Minimum Data Set (MDS) Assessment with a reference date of 5/13/16 due to a significant change. The MDS identified the resident had diagnoses that included anemia, hypertension (high blood pressure), non-Alzheimer's dementia and hip fracture, severe cognitive impairment with symptoms of delirium, and required extensive assistance of 2 or more staff members for transfers to and from bed and chair, bathing, dressing, toileting and personal hygiene. The MDS indicated the resident had daily behaviors not directed at others. A MDS Assessment with a reference date of 5/20/16 indicated the resident required continued extensive assistance by 2 or more staff members for transfers to and from bed and chair, bathing, dressing, toileting and personal. The MDS identified the resident displayed daily verbal behaviors that were directed at others and other daily behaviors not directed at others.	F 279	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 279	Continued From page 34 The resident's nursing Care Plan included a problem identified as activities of daily living (ADL) self-care deficit, with 8/3/16 goal for the resident to maintain current level of ADL function, and interventions that included: 1. Assist of 1 to 2 for transfers, initiated 5/6/16. 2. Floor alarm with pad for safety, initiated 5/28/16. 3. Sling to left arm at all times, initiated 6/20/16. 4. Extensive assistance by 1 staff for showers, initiated 12/30/15. 5. Limited assistance of 1 staff for dressing, initiated 2/28/16. 6. Supervision/assistance of 1 staff for eating, initiated 2/28/16. 7. Limited assistance of 1 staff for personal hygiene and oral care, initiated 2/28/16. 8. Limited assistance of 1 staff for toilet use, revised on 2/28/16. Another Care Plan problem identified was a fall with serious injury related to an unsteady gait, initiated on 6/1/16, with 8/9/16 goal that the resident's broken arm would heal without complication, and interventions that included: 1. Floor mat alarm by bed, initiated 6/1/16. 2. Hi-Lo bed in place, initiated 6/1/16. 3. Physical therapy consults for strength and mobility, initiated 6/17/16. Another Care Plan problem identified the resident with dementia, with 8/9/16 goal that the resident would be able to communicate basic needs on a daily basis, and interventions that included: 1. Cue, reorient and supervise as needed, initiated 2/28/16. 2. Keep the resident's routine consistent and try to provide consistent care givers as much as possible, initiated 2/28/16.	F 279	Please see attached	8-17-16

PRINTED: 09/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 279	Continued From page 35 3. Ask yes/no questions in order to determine the resident's needs, initiated 2/28/16. 4. Present just one thought, idea, question or command at a time, initiated 2/28/16. The resident's record indicated the following: The Incident/Accident Report form identified on 5/30/16 at 1:45 p.m., staff found the resident on the floor beside the bed and lying on left side. The report indicated the resident as confused and disoriented as was prior to the fall. No injuries were identified and the fall was unwitnessed. The Incident/Accident Report form indicated on 5/31/16 at 1:00 p.m., the staff found the resident on the floor on back in room. The resident yelled when the nurse attempted to assess the left arm. The report indicated the fall as unwitnessed and the facility sent the resident to the hospital. The resident had a diagnosed of a fractured left humerus (upper arm bone) and returned to the facility later the same day. Observations of the resident identified the following: On 6/20/16 at 12:29 p.m., the resident laid on back in bed with door open and made repeated yells "I need help, I need to get up". The yells were audible 4 resident rooms away from Resident #7's room. On 6/21/16 at 6:05 a.m., the door to the resident's room was closed and remained closed at 6:08 a.m. when a certified nursing assistant (CNA) stated no staff were in the room with the resident. On 6/22/16 at 11:14 a.m., Staff K, CNA, was interviewed and stated her assignment was the	F 279	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 279	Continued From page 36 hall of Resident#7 ' s room on 5/31/16 day shift. Staff K stated she did not put the resident in bed after lunch and did not know who did. The resident's door was closed and she stated she could hear the bed alarm going off [activated] as the resident yelled for help in the hallway near the resident's room after lunch. Staff K stated she opened the door and found the resident on the floor, on back and blood on arm. Staff K stated she stayed with the resident and yelled for help. Staff K stated the resident called out or yelled frequently. Staff K stated the residents and staff didn ' t like to hear it and shut Resident #7's door. Staff K stated she had instructed staff on repeated occasions they should not shut the resident's door because they could not hear the resident's alarms or calls for help when needed. Staff K stated the resident didn't use [activate] the call light. On 6/22/16 at 3:20 p.m., Staff Q, CNA, was interviewed and stated she worked the evening shift and Resident #7's hall on 5/30/16 and 5/31/16. Staff Q stated the resident had dementia and often didn't know what they were saying but yelled out. The staff and residents, especially the 2 in the room across the hall, didn't like to hear the resident's yells and closed the resident's door. Staff Q stated she was instructed by Staff G, licensed practical nurse (LPN), to position the resident on his/her left side (faced the wall) in order to decrease the noise audible in the hallway. Staff Q stated she instructed other CNA's that they should not shut the resident's door as they could not hear the resident's calls for help. On 6/22/16 at 5:40 p.m., Staff H, LPN (licensed practical nurse) and unit manager, stated the	F 279	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 279	Continued From page 37 resident's door was often closed without staff in the room. Staff H stated she had instructed the staff they could not close the resident's door and staff continued to leave the resident in the room alone with the door closed after instructed not to. On 6/22/16 at 7:35 p.m., Staff J, LPN, stated she worked the 6:00 p.m. to 6:00 a.m. shift, often found the resident's door closed without staff in the room, she opened the door and instructed staff to leave the door open at least a few inches in order to hear the alarms and resident's calls for help, and was an ongoing battle with the residents that lived in the same hall, Resident #7 yelled at night and other residents didn't like that. Staff J stated the resident would not use the call light. On 6/22/16 at 5:55 a.m., Staff F, CNA, was interviewed and stated she had worked on the night shift for over 3 years. Staff F stated the resident always called out at night and staff would check on the resident frequently, as the resident often attempted to get up on their own. Staff F stated after she/he broke their hip, the resident needed at least 1 staff person for support to stand. On 6/23/16 at 10:25 a.m., the MDS coordinator nurse stated she worked on the day shift on 5/31/16 and responded to the resident's fall. The MDS nurse stated the resident was on their back on the floor near the sink and no mat lay on the floor. The bed alarm was audible and hadn't been silenced. The MDS nurse stated Staff H was in the room with a CNA (didn ' t remember which CNA).	F 279	Please see attached	8-17-16
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281	Please see attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 281 SS=D	Continued From page 38 PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to follow physician's orders for 1 of 27 current residents reviewed, (Resident #5) The facility reported a census of 60 residents. Findings include: According to the 5/3/16 Minimum Data Set (MDS) assessment, Resident #5 diagnoses of seizure disorder, malnutrition and a heart malformation. The MDS identified the resident with intact memory and required extensive assistance with hygiene. Observation on 6/21/16 at 6:46 am revealed Resident #5 had a g-tube (gastric tube for nutrition). On 6/21/16 at 11:15 a.m. Staff G, Licensed Practical Nurse (LPN), reported Resident #5 had an appointment which usually lasted 3-4 hours. Staff G indicated the evening shift would need to flush resident's g-tube when the resident returned to the facility. Review of Resident #5's 4/26/16 hospital Discharge Summary documented the g-tube had been placed on 3/14/16, due to the resident experiencing dysphagia (difficulty swallowing) secondary to a stroke. The documentation revealed the resident tolerated a mechanical soft diet with honey thickened liquids while hospitalized.	F 281	Please See attached	8.12.16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 281	Continued From page 39 Review of the current plan of care revealed the g-tube in place but not used/needed for hydration or nutrition support at this time. The Physician's Order form dated 6/16 directed staff to flush the g-tube every day with 60 ml (milliliter) of tap water. Review of the Medication Administration Record (MAR) on 6/22/16 at 10:49 am revealed the water flush order signed as provided 11 of 22 days for the month of June 2016. Review of the documentation area provided on the back of the MAR revealed no refusal or omission documentation.	F 281	Please See attached	8-17-16
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, and review of facility documentation, the facility failed to appropriately assess and implement interventions for 1 resident following a physician appointment, continued follow-up physician's appointment for treatment of skin cancer and provide treatments for skin treatment for post biopsy site (Resident #27) and for 1 resident with a change of condition (Resident #10). The sample consisted of 27 residents and the facility reported a census of 60 residents.	F 309	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 309	Continued From page 40 Findings include: 1. Resident #27 had a MDS (Minimum Data Set) assessment with a reference date of 03/16/16. The MDS indicated the resident had diagnoses that included hypertension (elevated blood pressure), diabetes mellitus, mild cognitive impairment, opioid (narcotic) abuse, gastro-esophageal reflux disease. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15. A score of 11 identified the resident with a moderate cognitive impairment. The MDS indicated the resident to be independent with bed mobility, transfers, ambulation and toilet use, and required staff supervision for dressing, eating, and personal hygiene. The MDS indicated the resident had an admission date of 10/29/15. The Care Plan, dated 12/30/15, identified the resident had self-care performance deficits related to pain with activities of daily living. The interventions directed staff to assist with bathing/showering, dressing and personal hygiene. Review of Nursing Communications dated 2/16/16 indicated Resident #27 ' s biopsy site on the right temple should be gently cleansed with tap water followed by Vaseline and to bandage every day until healed, per the dermatologist. Review of the dermatologist [physician] notes dated 2/16/16, indicated Resident #27 was referred by his/her personal medical doctor because of a sore on the right temple, crusting spot on right forehead, and rash on face. The plan consisted of a shave biopsy to the area of the right temple. On 2/25/16 the pathology report of the biopsy revealed basal cell carcinoma with infiltrating features and depth of the biopsy extensively involved. A Mohs surgery procedure (also known as Chemosurgery) is indicated for	F 309	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 309	Continued From page 41 maximum tissue conservation and to try and preserve the temporal branch of the seventh cranial nerve. On 2/29/16 the resident was informed of pathology results and the need for Mohs surgery discussed. The Mohs surgical procedure was arranged for 3/7/16. Review of the dermatologist physician note dated 3/28/16, indicated the facility called the physician ' s office and reported Resident #27 to be ill and unable to make the scheduled appointment for the Mohs surgical procedure today. The facility rescheduled the appointment for 4/11/16. Review of the dermatologist physician note dated 4/11/16, indicated the physician ' s office called the facility to make sure Resident #27 was going to make the scheduled appointment. The facility administrator informed the physician the bus had already left that would take the resident to the appointment thus the resident is unable to make the appointment again. A new appointment was made for 4/18/16. The physician discussed his frustration with the facility Administrator that this is the third time the coordination for the resident ' s surgery been missed. The Administrator informed the physician that she would personally call and arrange transportation for the 4/18/16 appointment. Review of the dermatologist ' s note dated 4/14/16 indicated the physician received a call from the facility informing him they are unable to provide transportation for Resident #27 scheduled appointment on 4/18/16. The physician rescheduled the resident ' s appointment for 5/2/16. The physician stressed to the facility the importance of keeping this appointment because it has been rescheduled now five times. Review of the dermatologists physician note dated 5/2/16 indicated Resident #27 again failed to show up for his/her scheduled appointment for	F 309	Please See attached	7-26-16

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

PRINTED: 06/05/2016
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
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 309	Continued From page 42 the surgical procedure of Mohs. The physician staff called the facility and the staff informed the office staff that their office had called and cancelled the appointment. The note identified this as false. The physician documented he spoke with the Administrator who said the resident had surgery at another location on 4/29/16 and she is unaware of why the resident had the procedure done at the other location or why this physician had not been notified that the resident would not be attending the scheduled appointment with this physician. The physician indicated that it is so difficult to get proper coordination of care with the facility for the resident; the physician decided to phone the resident ' s primary care physician office for coordination of the resident ' s care of the skin cancer as the facility cannot coordinate transportation for the resident. Review of the physician note dated 5/9/16 indicated the physician received a call from Resident #27 primary care physician indicating the resident sent to another physician for treatment of a skin lesion and they are unaware of how the resident ended up at another physician ' s office for treatment as the primary care physician had not referred the resident for that treatment. On 5/2/16 the dermatologist wrote a letter to Resident #27, and indicated the resident was evaluated for a non-healing lesion of the right temple. The biopsy revealed a basal cell carcinoma, which is a type of skin cancer. Subsequently, the physician ' s office arranged four separate times for surgical procedure of this tumor to be performed here at the office. The surgical date has been rescheduled on four separate occasions now. Most recently, Resident #27 was supposed to show up today, May 2nd at	F 309	Please see attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 309	Continued From page 43 8:00 a.m. for the procedure. Once again, Resident #27 not transported to the physician ' s office for the procedure. The physician ' s office phoned the facility and the facility claimed the physician ' s office called and canceled the appointment. The physician indicated this is completely untrue. The facility claimed the resident had some sort of surgical procedure performed on Friday at another location. The physician indicated not having any idea if it was for the resident ' s basal cell carcinoma or another procedure. The physician indicated with the above difficulties in mind, the physician phoned the resident ' s primary care physician ' s office and reported the frustrations with the facility. The physician indicated if the resident has not had the basal cell carcinoma surgically excised, then the resident needs to have this done locally where transportation is not such a difficult issue. The primary care physician ' s office informed the dermatologist they will look into this and report when this gets arranged to care for the resident ' s problem. Review of Resident #27 clinical record lacked indication of follow appointments being scheduled or rescheduled. Review of Resident #27 Visit Summary dated 4/29/16, revealed the resident presents in consultation from primary care physician for evaluation of a lesion on the right temple that has been present for 5 years. The resident reports it bleeds occasionally bleeds and sometimes hurts. The resident reports that it may have been biopsied in the past. The physician called the resident ' s primary care physician office and they indicated per their records, the resident has never had a biopsy of the right temple. A shaved biopsy performed, wound instructions given, resident to follow-up in 6 months or sooner pending biopsy	F 309	Please see attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 309	Continued From page 44 results. An addendum dated 5/3/2016 indicated the pathology results were relayed to the resident and a facility nurse. The pathology revealed basal cell carcinoma, with infiltrative features, associated with squamatized epidermal proliferation with features of seborrheic keratosis, and adjacent scar. The resident reports that the facility has not been performing wound care. The physician spoke with the facility nurse, who confirmed that wound care has not been performed for the last couple days. The physician stressed the importance of proper wound care and reiterated the instructions of wound care, and the nurse agreed to have this restarted. The nurse does not think the area looks infected; no surrounding redness or purulent drainage. The physician indicated the resident to undergo Mohs surgery, the facial location where tissue conservation is critical. The physician discussed the risks, benefits and alternatives as well as repair options that are often uncertain until the lesion has been excised, discussed that the surgical defect may be larger than the clinically evident by lesion. Review of Resident #27 clinical record lacked indication of the physician ' s conversation with the facility, or any surgical appointment being scheduled for the resident. An interview was conducted on 5/13/16 at 12:10 p.m. with Staff FF, Registered Nurse (RN). Staff FF stated she received a phone call on 4/29/16 from Resident #27 physician. Staff A reported the physician asked her if the resident has had a biopsy done to the left temple lesion. Staff FF stated she told the physician the resident had one done a couple months ago. Staff FF stated she did not document this conversation in the resident ' s clinical record. Staff FF stated she did not know the resident had missed the follow-up	F 309	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 309	Continued From page 45 biopsy appointments from 2/16/16. Staff FF stated noting was documented on the appointment calendar or the resident ' s record of the appointments or why they got canceled. Staff FF stated she was not aware of the missed appointments or the follow-up appointment for surgery from the resident ' s 4/29/16 appointment until the surveyor asked about them. Staff FF stated she did not know who the physician, she talked to on 4/29/16, although she spoke with the physician, and nothing documented. Staff FF stated she would expect staff to document this. Staff FF further stated the resident ' s appointments fell through the cracks. 2. Resident #10 had a MDS with a reference date of 5/27/16. The resident listed diagnoses for Resident #10 which included non-Alzheimer's dementia, anxiety disorder, depression, schizophrenia, and somatization disorder. The MDS stated the resident required extensive assistance of 1 staff member for dressing, personal hygiene, and bathing, and supervision and set up assistance of 1 staff for eating and toilet use. The MDS listed the resident as having inattention, disorganized thinking, physical and verbal behavioral symptoms directed toward others, and other behavioral symptoms not directed toward others. The MDS listed the resident's BIMS (Brief Interview for Mental Status) score as 13. A score of 13 identified no cognitive problems. An Incident report for Resident #10, dated 6/9/16, identified the resident as yelling in the room and staff attempted to calm the resident. The resident had a 0.5 cm (centimeters) x [by] 0.5 cm area to the forehead.	F 309	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 309	Continued From page 46 A Progress Note for Resident #10, dated 6/9/16 at 8:49 a.m., indicated the resident had a red area located on the right side of the forehead. The notes documented the nurse asked the resident how he/she received the area and the resident did not answer the nurse. The note indicated the neurological checks were within normal limits. The facility lacked documentation of any further neurological checks and the progress notes lacked information regarding Resident #10 refusing any further neurological checks. An undated skin assessment sheet for Resident #10 documented the resident had a red area located on the forehead and measured 0.5 cm x 0.5 cm. An incident report for Resident #10, dated 6/9/16, indicated a staff member witnessed the resident hitting his/her head on the headboard, causing a red area to the right side of the forehead. Review of Progress Notes from 6/9/16-6/12/16 at 5:30 p.m. (when the family inquired with the facility regarding the resident's condition) revealed no mention of the resident with unclear speech and being unsteady. No further measurements were in the resident's record regarding the resident's forehead bruising, other than the 0.5 cm x 0.5 cm measurement. A Progress Note, dated 6/12/16 at 6:39 p.m., indicated the family had spoken to the facility regarding the resident ' s bruise to the right side of the forehead that had also moved down to the ear. The note indicated the family was also	F 309	Please see attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 309	Continued From page 47 concerned because the resident had garbled speech and unsteady on his/her feet. The note indicated the facility sent the resident to the emergency room. The hospital emergency department notes, dated 6/12/16 at 8:55 p.m., indicated the resident arrived in the emergency room and had bruising over the right eye, ear, right chest, and right thigh. Photographs provided by Resident #10's daughter, time stamped 6/13/16, identified the resident with the following skin areas: a. a purple and black bruise covering an approximate 5 cm x 5 cm area on the forehead above the right eye, b. a yellow and black bruise covering an approximate 5 cm x 5 cm area on the right shoulder c. a gray bruise on the right forearm d. a red area on the right side of the chest e. bruised areas to both knees The facility lacked documentation of any bruising on the right chest, right forearm, knees, and right thigh and documented the size of the forehead bruise as 0.5 x 0.5 cm. The radiology reports dated 6/12/16 at 6:30 p.m. indicated the radiological findings most likely represented acute infarcts in the left frontal lobe and left occipital temporal lobe (strokes in 2 regions of the brain). The facility Change in a Resident's Condition or Status policy, revised April 2014, directed the staff if a significant change in the resident's physical or mental condition occurred, a comprehensive assessment of the resident's condition would be conducted.	F 309	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 309	Continued From page 48 On 6/22/16 at 5:52 a.m., Staff CC CNA (Certified Nursing Assistant) was interviewed and stated she had worked the night shift on 6/8/16 and noticed Resident #10 leaning to the side and very stiff. The resident had outbursts and had taken the nebulizer and had put it up to his/her face. She stated the resident's speech was garbled and she could not make sense of what he/she was saying. The resident placed himself/herself on the floor a couple of times and she thought the resident had bumped his/her elbow possibly but not head. Staff CC stated she and a nurse helped return the resident to bed. Toward the end of her shift, she heard the resident in bed yelling. Staff CC stated she went in the room and the resident had a "goose egg" about the size of a quarter on his/her forehead. She stated she thought the resident had taken his/her nebulizer and struck it against his/her head. She stated Staff G LPN (Licensed Practical Nurse) and Staff A CNA/CMA (Certified Medication Assistant) came to the room to assess the resident. She stated she thought Staff G and Staff A knew the resident's speech was garbled. Staff CC stated she worked the night shift on 6/10/16 and the resident's speech seemed more garbled and he/she hardly had any clear speech. She stated this was strange for the resident. She stated she worked the night shift again on 6/11/16 and the resident's speech was still garbled. During an interview on 6/22/16 at 5:08 p.m., the Director of Nursing stated Staff BB CMA told her Resident #10 had banged his/her head on the bed. She stated after a head injury neurological checks should be done until the physician stated otherwise.	F 309	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 309	Continued From page 49 On 6/22/16 at 4:53 p.m., the MDS Coordinator was interviewed and stated on 6/8/16 or 6/9/16, Staff G LPN (licensed practical nurse) told her the resident had a spot on his/her head. The MDS Coordinator stated staff told her the resident had been swinging and banging his/her head. She stated neurological checks should have been done but they couldn't because the resident was so agitated and stated she told the nurses to call the hospital but she was not sure if that was done. She stated neurological checks after a head injury should be performed every 15 minutes for 4 times, every 30 minutes for 4 times, every hour for 4 times, every 4 hours for 4 times, and then every shift for 72 hours. She stated if the resident refused, it would be in the progress notes. The MDS Coordinator stated the facility should notify the family when such events occurred. She stated that on 6/11/16, the resident placed himself/herself on the floor and Staff DD CNA witnessed this. She stated the resident stood up and had no problems and that his/her neurological checks were within normal limits. During an interview on 6/22/16 at 6:49 a.m., Staff G LPN stated she worked the day shift on 6/9/16. She stated the resident had been yelling and screaming and was given an anti-anxiety medication. She stated the resident had a red area on the forehead but that she didn't know what happened. She stated the resident had no abnormal speech. Staff G stated she worked again on the day shift of 6/12/16 and that the resident had no abnormal speech on this shift. She stated that the resident's daughter and wife came in that day and inquired about the resident's bruising. Staff G stated she went in the resident's room and he/she had bruising on his/her ear and	F 309	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 309	Continued From page 50 had a "little raised area" on his forehead which was "dime sized". She stated she consulted with the physician and called an ambulance for the resident. During an interview on 6/22/16 at 1:47 p.m., Staff A CNA/CMA stated that on 6/10/16 she worked the day shift and had heard that the resident "bolted" across the unit to the shower room and threw himself/herself on the floor. She stated she helped the nurse assess the resident as he/she was laying on his/her right side in the shower room. She stated the resident had already had a bruise but that she thought he hit his/her head again. Staff A stated the incident was unwitnessed but Staff K, CNA told her she heard a thud. She stated on this shift the resident's speech was "a little more slurred". On 6/21/16 at 6:04 p.m., Staff H, RN (Registered Nurse) was interviewed and stated when she worked the night shift on 6/10/16; she did not notice any speech problems. She stated that the week before she had noticed the resident leaning to the left when she took him to his/her doctor's appointment. Staff H stated she worked the night shift on 6/11/16 and described the resident's speech as "a little off but normal" for the resident. On 6/21/16 at 9:13 a.m., Staff BB, CMA was interviewed and stated the resident hit his/her head on the headboard and had been "more angry" the last couple of weeks. She stated when she worked on 6/9/16, there was only a red mark on the resident's forehead but when she next saw the resident around noon on 6/10/16, she was "in shock" by the look of the bruise. Staff BB stated the resident said he/she did not know how the bruise happened. Staff BB stated she attributed	F 309	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 309	Continued From page 51 the bruising to the resident banging his/her head on the bed. Staff BB stated when she saw the resident again on 6/11/16, his/her speech was in and out but more garbled. Staff BB stated the resident always had some speech difficulty because he/she had clenched teeth. During an interview on 6/22/16 at 11:56 a.m., the resident's physician stated the resident had a stroke prior to arriving at the hospital but could not identify a specific time frame. The physician stated the resident arrived at the hospital with various bruises.	F 309	Please See attached	7-26-16
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to provide the two baths or showers a week for 8 of 13 residents reviewed for personal hygiene needs (Resident #1, #2, #4, #5, #11, #16, #17, #18.) The facility reported a census of 60 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 4/14/16 identified Resident #1's diagnoses to include Parkinson's disease. The MDS revealed the resident with a BIMS (Brief Interview	F 312	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 312	Continued From page 52 for Mental Status) score of 15 of 15, indicating the resident with no short or long term memory problems and no problems with cognitive skills for daily decision making skills. The Care Plan dated 5/2/2016 included a problem of the resident having an Activity of Daily Living (ADL) self-care performance deficit related to Parkinson's disease. The care plan directed staff the resident requires extensive assistance by one staff for showering twice weekly and as necessary. Resident #1's May 2016 flowsheet listed under Interventions: ADL-bathing, revealed documentation indicated a bath or shower only provided May 16th, 2016. During an interview on 5/13/16 at 12:30 p.m., Resident #1 stated since admission on 4/7/16 he/she had only received 3 showers. Resident #1 stated he/she washes up at the sink in his/her room. Resident #1 stated he asked staff this morning if he/she could get placed back on the shower list. 2. During an interview on 6/21/16 at 7:08 a.m. Resident #1 reported he/she would like to have two baths per week. Upon record review of the resident's Shower Skin Sheets and Intervention Sheets for April, May, and June of this year the documentation revealed that the resident did not receive two baths the week of May 22nd, or May 29th. The facility did not provide the June bathing documentation. Upon further record review the resident's chart lacked documentation as to why the baths were not completed for the weeks May 22nd, and May	F 312	Please see attached	7.12.16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 312	Continued From page 53 29th. 3. The MDS assessment dated 5/5/16 for Resident #2 documented the resident scored a 14 out of 15 on the BIMS, indicating intact cognition. The MDS revealed that the resident required extensive assistance of one person for bathing. The MDS documented the resident had diagnoses including peripheral vascular disease, diabetes mellitus, and chronic pain. The MDS identified the resident with an unhealed pressure ulcer. The resident's Care Plan identified a focus area on 5/5/16 that the resident had a self care performance deficit. The Care Plan directed staff to provide the resident with extensive assistance of one staff member for showering twice a week and as necessary. Upon record review of the resident's Skin Shower Sheets and Intervention Sheets for April, May, and June of this year the documentation revealed that the resident only had four showers the month of April, three showers the month of May, and no documentation provided for showers in the month of June. The record lacked documentation as to why the two baths a week did not happen. 4. The Quarterly MDS assessment dated 4/14/16 documented Resident#16 had scored a 15 out of 15 for the BIMS indicating intact cognition. The MDS revealed that the resident required extensive assistance of one person for bathing. The MDS documented the resident had diagnoses including asthma, morbid obesity, infection of the skin, and depression. The resident's Care Plan identified a focus on	F 312	Please see attached	8-17-16

PRINTED: 06/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 312	Continued From page 54 12/30/15 as a performance deficit in self-care related to morbid obesity. The Care Plan directed staff to provide the resident with a shower or bath twice a week with extensive assistance of one staff member. Upon record review of the resident's Skin Shower Sheets and Intervention Sheets for April, May, and June of this year, the documentation revealed the resident only had four showers during that time period. The record lacked documentation as to why two baths a week did not occur. 5. The Admission MDS assessment dated 5/2/16 for Resident#17 documented the resident scored a 15 out 15 for the BIMS, indicating intact cognition. The MDS identified the resident required total assistance of one staff member for bathing. The MDS documented that the resident had diagnoses including morbid obesity, heart failure, and diabetes. The Care Plan lacked direction to staff related to the resident's bathing. Upon record review of the resident's Skin Shower Sheets and Intervention Sheets for April, May, and June of this year the documentation revealed the resident had only two showers or baths for the time period reviewed. The record lacked documentation as to why two baths a week did not occur for the resident. 6. The Quarterly MDS assessment dated 5/11/16 for Resident#18 documented that the resident scored a 15 out 15 for the BIMS, indicating intact cognition. The MDS indicated the resident required total assistance of one staff member for	F 312	Please See attached	7-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 312	Continued From page 55 bathing. The MDS documented that the resident had diagnoses including a stroke, morbid obesity, and diabetes. The Care Plan identified a focus area dated 12/30/15 as self-care performance deficit related to a stroke. The Care Plan directed staff to provide extensive assistance of one staff member for showering twice a week. Upon record review of the resident's Skin Shower Sheets and Intervention Sheets for April, May, and June of this year the documentation revealed that the resident only had five showers for the time period reviewed. The record lacked documentation as to why the two baths a week did not occur. During an interview on 6/22/16 at 7:30 a.m. Staff A, Certified Nurse Aide (CNA) reported she works 12 hours shifts, 6:00 a.m. to 6:00 pm., and that the residents are getting at least one bath a week, but the residents should get two baths a week. Staff A reported baths are not getting done because the facility can't get enough staff hired or keep the staff they have. During an interview on 6/22/16 at 10:51 a.m. Staff U, CNA, reported that each hall gets a bath list, and you document the baths on Shower Skin Sheets. The Shower Skin Sheets are used to document the baths, any skin issues that the resident may have, and then they are given to the nurse to sign. If a resident refused, or if the resident is in the hospital you document that on the Shower Skin Sheet. If you are not able to get the bath done you pass the information onto the second shift, and check with the resident the next day. If a resident refused a bath the CNA should	F 312	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 312	Continued From page 56 tell the nurse, and the nurse will coach the resident. Staff are to reapproach the resident at least two times, and document the reapproach. During an interview on 6/22/16 at 9:00 a.m. Staff R, Registered Nurse, reported the CNA give the Skin Sheets to the nurse after the resident had been given a bath. If a resident refuses then another staff member will reapproach the resident to see if she/he will comply with a bath, if the resident refuses a second time then the CNA will chart a refusal of the bath in the CNA books. During resident group interview on 6/21/16 at 1:48 p.m. 4 of 6 residents reported that they did not get two showers or baths per week. The residents reported that the facility did not have enough help. During an interview on 6/22/16 at 9:13 a.m. Staff M, CNA, reported residents are given baths twice a week. There are hall books for the CNA to check the schedules for the resident's baths, and the CNAs fill out bath sheets, and give them to the nurses to sign. If a resident refuses a bath the resident is reapproached three times by the CNA, then the nurse talks to the resident. The resident refusals are charted by the CNA on the bath sheets and the nurse signs that, after the three refusals. 7. The MDS assessment, dated 5/12/16, listed diagnoses for Resident #11 which included seizure disorder, psychotic disorder, and legal blindness. The MDS stated the resident required extensive assistance of 1 staff for bed mobility, transfers, dressing, and bathing, limited assistance of 1 staff for personal hygiene, and totally depended on 1 staff for toilet use. The	F 312	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 312	Continued From page 57 MDS listed the resident's BIMS score as 14 out of 15, indicating intact cognition. The care plan for Resident #11, revised 5/10/16, stated the resident required assistance of 1 staff for showering twice a week and as necessary. The June bath schedule for Resident #11 showed that staff documented assisting the resident with a bath on 6/7/16. The schedule lacked any further documentation of staff assisting the resident with bathing during the period of 6/1/16 and 6/22/16. During an interview on 6/22/16 at 8:00 p.m., Resident #11 stated he/she was lucky to have 1 shower per week and rarely had 2 showers per week. The resident stated staff told him/her the reason he/she did not get showers was because they needed more staff. The resident stated he/she would like more than 1 shower per week, especially in the summer. During an interview on 6/22/16 at 5:08 p.m., the Director of Nursing stated residents should have 2 showers per week. 8. According to the 3/10/16 MDS Resident #4 had diagnoses which included diabetes mellitus, non-Alzheimer's dementia, seizure disorder and obesity. The MDS documented Resident #4 required extensive assistance of one staff member for bathing. The resident's current Care Plan identified an ADL self-care deficit related to history of mental disorder and directed staff to provide extensive assistance by 1 staff with shower twice a week and as necessary. Record review revealed Resident #4 offered a	F 312	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 312	Continued From page 58 bath/shower only 6 times in May instead of the specified 9 times in May. Resident #4 refused a bath/shower 4 out of the 6 times offered. Record review revealed Resident #4 offered a bath/shower 3 times in June instead of the specified 7 times thus far in June. Resident #4 refused a bath/shower 2 out of 3 times offered. 9. The 5/3/16 MDS documented Resident #5 with diagnoses which included seizure disorder, malnutrition and history of heart malformation and totally dependent on bathing assistance with the extensive assistance of one staff member. The resident's current Care Plan directed staff to provide bathing/showering two times a week with extensive assistance by 1 staff member. Record review revealed Resident #5 offered a bath/shower only 4 times in May instead of the specified 9 times in May. Resident #5 received a bath/shower when offered the 4 times in May. Record review revealed resident #5 offered a bath/shower only 2 times in June instead of the specified 7 times thus far in June. Resident #5 received a bath/shower when offered the 2 times thus far in June. During an interview on 6/22/16 at 8:56 am, the Director of Nursing reported there is a list of showers that need to be completed at each hall's nurse's station. The nurses make the CNA's assignments and the CNAs are expected to complete the showers and document them in the bath/shower book that is located at each nurse's station. Interview on 6/22/16 at 9:30 am with the Staff Development Coordinator revealed there are CNA task sheets for each resident that tell staff how to care for the residents but are more than likely not updated. The Staff Development Coordinator went to show the task sheets in Hall 1 but there were no sheets. On Hall 2 found only	F 312	Please See attached	7-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 312	Continued From page 59 task sheets for 2 residents. Hall 1 task sheets should consist of sheets for residents in 100, 200, and 300 rooms. Hall 2 tasks sheets should consist of sheets for residents in 400, 500 and 600 rooms.	F 312	Please see attached	8-17-16
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide adequate nursing supervision to prevent accidents and ensure a resident's environment remained as free of accident hazards as possible and failed to revise the Care Plan with interventions to ensure the planned alarms could be heard by staff for 1 of 5 residents reviewed with a recent fall history (Resident #7). The facility reported a census of 60 residents. Findings include: Resident #7 had a Minimum Data Set (MDS) Assessment with a reference date of 5/13/16 due to a significant change. The MDS identified the resident had diagnoses that included anemia, hypertension (high blood pressure), non-Alzheimer's dementia and hip fracture,	F 323	Please see attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 323	Continued From page 60 severe cognitive impairment with symptoms of delirium, and required extensive assistance of 2 or more staff members for transfers to and from bed and chair, bathing, dressing, toileting and personal hygiene. The MDS indicated the resident had daily behaviors not directed at others. A MDS Assessment with a reference date of 5/20/16 indicated the resident required continued extensive assistance by 2 or more staff members for transfers to and from bed and chair, bathing, dressing, toileting and personal. The MDS identified the resident displayed daily verbal behaviors that were directed at others and other daily behaviors not directed at others. The resident's nursing Care Plan included a problem identified as activities of daily living (ADL) self-care deficit, with 8/3/16 goal for the resident to maintain current level of ADL function, and interventions that included: 1. Assist of 1 to 2 for transfers, initiated 5/6/16. 2. Floor alarm with pad for safety, initiated 5/28/16. 3. Sling to left arm at all times, initiated 6/20/16. 4. Extensive assistance by 1 staff for showers, initiated 12/30/15. 5. Limited assistance of 1 staff for dressing, initiated 2/28/16. 6. Supervision/assistance of 1 staff for eating, initiated 2/28/16. 7. Limited assistance of 1 staff for personal hygiene and oral care, initiated 2/28/16. 8. Limited assistance of 1 staff for toilet use, revised on 2/28/16. Another Care Plan problem identified was a fall with serious injury related to an unsteady gait,	F 323	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 323	Continued From page 61 Initiated on 6/1/16, with 8/9/16 goal that the resident's broken arm would heal without complication, and interventions that included: 1. Floor mat alarm by bed, initiated 6/1/16. 2. Hi-Lo bed in place, initiated 6/1/16. 3. Physical therapy consults for strength and mobility, initiated 6/17/16. Another Care Plan problem identified the resident with dementia, with 8/9/16 goal that the resident would be able to communicate basic needs on a daily basis, and interventions that included: 1. Cue, reorient and supervise as needed, initiated 2/28/16. 2. Keep the resident's routine consistent and try to provide consistent care givers as much as possible, initiated 2/28/16. 3. Ask yes/no questions in order to determine the resident's needs, initiated 2/28/16. 4. Present just one thought, idea, question or command at a time, initiated 2/28/16. The resident's record indicated the following: The Incident/Accident Report form identified on 5/30/16 at 1:45 p.m., staff found the resident on the floor beside the bed and lying on left side. The report indicated the resident as confused and disoriented as was prior to the fall. No injuries were identified and the fall was unwitnessed. The Incident/Accident Report form indicated on 5/31/16 at 1:00 p.m., the staff found the resident on the floor on back in room. The resident yelled when the nurse attempted to assess the left arm. The report indicated the fall as unwitnessed and the facility sent the resident to the hospital. The resident had a diagnosed of a fractured left humerus (upper arm bone) and returned to the facility later the same day.	F 323	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 323	Continued From page 62 Observations of the resident identified the following: On 6/20/16 at 12:29 p.m., the resident laid on back in bed with door open and made repeated yells "I need help, I need to get up". The yells were audible 4 resident rooms away from Resident #7's room. On 6/21/16 at 6:05 a.m., the door to the resident's room was closed and remained closed at 6:08 a.m. when a certified nursing assistant (CNA) stated no staff were in the room with the resident. On 6/21/16 at 8:34 a.m., the staff person placed the resident at a dining room table with 2 other residents that had food and beverages. Resident #7 asked the residents for their juice and then yelled "I need something to drink" several times. On 6/21/16 at 12:25 p.m., the resident seated in the dining room after the meal was completed and made repeated yells "help me, I'm afraid", and "my arm hurts, I need to go to the doctor". Staff did not respond to the resident's yells but a neighboring resident explained the resident's arm was broken and attempted to calm the resident. The resident then had repeated unanswered yells "my arm is broken; I ' ve got to go to the doctor". On 6/22/16 at 5:50 a.m., the door to the resident's room was closed and observation identified no staff present in the room with the resident. On 6/22/16 at 11:14 a.m., Staff K, CNA, was interviewed and stated her assignment was the hall of Resident#7 ' s room on 5/31/16 day shift. Staff K stated she did not put the resident in bed	F 323	Please See attached	7-26-16

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

PRINTED: 08/05/2016
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
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 323	Continued From page 63 after lunch and did not know who did. The resident's door was closed and she stated she could hear the bed alarm going off [activated] as the resident yelled for help in the hallway near the resident's room after lunch. Staff K stated she opened the door and found the resident on the floor, on back and blood on arm. Staff K stated she stayed with the resident and yelled for help. Staff K stated the resident called out or yelled frequently. Staff K stated the residents and staff didn ' t like to hear it and shut Resident #7's door. Staff K stated she had instructed staff on repeated occasions they should not shut the resident's door because they could not hear the resident's alarms or calls for help when needed. Staff K stated the resident didn't use [activate] the call light. On 6/22/16 at 3:20 p.m., Staff Q, CNA, was interviewed and stated she worked the evening shift and Resident #7's hall on 5/30/16 and 5/31/16. Staff Q stated the resident had dementia and often didn't know what they were saying but yelled out. The staff and residents, especially the 2 in the room across the hall, didn't like to hear the resident's yells and closed the resident's door. Staff Q stated she was instructed by Staff G, licensed practical nurse (LPN), to position the resident on his/her left side (faced the wall) in order to decrease the noise audible in the hallway. Staff Q stated she instructed other CNA's that they should not shut the resident's door as they could not hear the resident's calls for help. On 6/22/16 at 5:40 p.m., Staff H, LPN (licensed practical nurse) and unit manager, stated the resident's door was often closed without staff in the room. Staff H stated she had instructed the	F 323	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 323	Continued From page 64 staff they could not close the resident's door and staff continued to leave the resident in the room alone with the door closed after instructed not to. On 6/22/16 at 7:35 p.m., Staff J, LPN, stated she worked the 6:00 p.m. to 6:00 a.m. shift, often found the resident's door closed without staff in the room, she opened the door and instructed staff to leave the door open at least a few inches in order to hear the alarms and resident's calls for help, and was an ongoing battle with the residents that lived in the same hall. Resident #7 yelled at night and other residents didn't like that. Staff J stated the resident would not use the call light. On 6/22/16 at 5:55 a.m., Staff F, CNA, was interviewed and stated she had worked on the night shift for over 3 years. Staff F stated the resident always called out at night and staff would check on the resident frequently, as the resident often attempted to get up on their own. Staff F stated after she/he broke their hip, the resident needed at least 1 staff person for support to stand. On 6/23/16 at 10:25 a.m., the MDS coordinator nurse stated she worked on the day shift on 5/31/16 and responded to the resident's fall. The MDS nurse stated the resident was on their back on the floor near the sink and no matt lay on the floor. The bed alarm was audible and hadn't been silenced. The MDS nurse stated Staff H was in the room with a CNA (didn't remember which CNA).	F 323	Please See attached	7-26-16
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329	Please See attached	7-26-16

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

PRINTED: 08/05/2016
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
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 329	Continued From page 65 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure residents were monitored for nonpharmacological interventions prior to the administration of an anti-anxiety medication (Resident #8) and failed to administer medication (Sinemet) as ordered by the physician (Resident #1). The sample consisted of 27 residents and the facility reported a census of 60 residents. Findings include:	F 329	Pleas See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 329	Continued From page 66 1. Resident #1 had a MDS (Minimum Data Set) assessment with a reference date of 4/14/16. The MDS identified Resident #1 with diagnoses including heart failure, gastroesophageal reflux disease, renal insufficiency, diabetes mellitus, hyperlipidemia, non-Alzheimer's dementia, Parkinson's disease, seizure disorder, and asthma. The MDS indicated the resident had a BIMs (Brief Interview for Mental Status) score of 15 of 15. A score of 15 represented no short or long term memory problems and no problems with cognitive skills for daily decision. The MDS identified the resident required limited assist of one staff member for bed mobility, ambulation in room, and dressing. The MDS determined the resident to be independent with transfers, location on and off the unit, toilet use and personal hygiene. The Care Plan dated 5/2/2016 included a problem of high risk for falls related to Parkinson ' s and seizure disorder. The Care Plan interventions included and directed staff to administer medications as ordered, monitor and document for effectiveness and side effects. The Progress Notes dated 5/2/16 at 6:57 p.m. n indicated at 5:26 p.m. the nurse, Staff G, received a phone call from the hospital on-call nurse stating they have Resident #1 on the phone with possibly having a seizure. Staff G entered Resident ' s #1 room and the resident found lying on the floor between the wheelchair and bedside stand, head under the bed and positioned on stomach. Staff G moved all objects surrounding the resident and placed a pillow under the resident ' s head and heels. Upon assessment of the resident no lacerations, bruising or bumps to the head or body. At 5:25 p.m. Staff G placed a	F 329	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 329	Continued From page 67 call to the resident ' s physician and received an order to send the resident to the emergency room for further evaluation. The resident left the facility at 5:58 p.m. via ambulance continued to seize as leaving the facility. On 5/13/16 at 12:30 p.m. Resident #1 was interviewed and stated on 5/2/2016, he/she did not receive the scheduled 2 p.m. Sinemet medication. Resident #1 stated when he/she slept until 4 p.m. and the staff did not wake him/her for the 2 p.m. medication administration of Sinemet. Resident #1 stated he/she woke up at 4 p.m. and went to get his/her Sinmet medication from Staff EE, Certified Medication Aide (CMA). Resident #1 stated at 5 p.m. Staff EE administered the 2 p.m. dose and the 6 p.m. dose at the same time. Resident #1 stated he/she asked Staff EE before taking the medication if it would be safe to take all the medication at once and Staff EE said "I think so". Resident #1 stated he/she took the medication, which is a double dose of Sinmet. Resident #1 stated Staff EE never even checked with the nurse if it would be alright to take a double dose. Resident #1 stated he/she lay down in bed and about a half hour later he/she felt like the room spun. The resident stated he/she, could not see and had the call light on for 15 minutes. Resident #1 stated he/she attempted to transfer to a wheelchair and fell to the floor. Resident #1 stated he/she then called the on-call hospital nurse and got on the phone with that nurse about 25 minutes; the on-call nurse phoned the facility while he/she remained on the phone, and the facility nurse came into his/her room then and Resident #1 passed out at that time. Resident #1 stated they transferred him/her to the local hospital and then transferred to another hospital and he/she remembers waking up and being on	F 329	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 329	Continued From page 68 life support in the intensive care unit of the hospital. Resident #1 stated he/she had continuous seizure activity and the double dose of Sinemet affected his/her heart. Resident #1 stated he/she reported this to the DON (Director of Nursing) and the DON said he would be writing up [discipline] Staff EE for administrating a double dose of Sinemet. Review of the Discharge Summary dated 5/5/16 indicated Resident #1 was admitted on 5/2/16 and discharged on 5/5/16. Resident #1 principal diagnoses included: epilepsy with other pertinent diagnoses: morbid obesity, cerebral arteriovenous malformation, seizure, Parkinson ' s disease, obstructive pulmonary disease, methicillin resistant staphylococcus aureus (MRSA) pneumonia, cerebral aneurysm, lumbar spinal stenosis (narrowing of lumbar vertebrae), On arrival the resident intubated and sedated, Resident able to be extubated the next day. Resident discharged on 5/5/16 back to skilled nursing facility. On 5/19/16 at 4:15 p.m. the Director of Nursing (DON) was interviewed and stated Resident #1 reported to her on 5/6/16 about medication administration. The DON stated she had not had a chance to investigate the issues. The DON stated the resident had just returned from the hospital when he/she reported concerns. The DON stated the resident was to confused at the time of reporting this. The DON further stated staff should never double up on a missed dose of medication with the next schedule time of medication. The DON stated if a dose is missed then staff are to fill out a medication error, monitor the resident, notify the resident ' s physician and family and document in the nurse '	F 329	Please see attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 329	Continued From page 69 s notes. The DON stated no medication error report was completed for Resident #1. On 5/20/16 at 2:11 p.m., Staff EE, CMA (Certified Medication Aide) was interviewed and stated on 5/2/16 she worked on the floor [giving cares] until 5:00 p.m. when asked to administer medications. Staff EE stated Resident #1 came up to her and said he/she never received their 2 p.m. Sinemet medication. Staff EE stated Staff G, nurse, stood by her and said "oh shoot " and Staff G gave the 2 p.m. dose. Staff EE stated she then immediately gave the resident the 6 p.m. dose of Sinemet and she signed out administering the 2 p.m. dose, even though she did not give it, and the 6 p.m. dose. Staff EE stated the resident did question her if it is ok to give both doses together and Staff EE stated she did not have an answer for that but did tell the resident that it should be ok. Staff EE stated she never checked with the nurse if it is ok to give back to back doses of Sinemet and never reported to the nurse that she gave back to back doses of Sinemet to the resident. Staff EE further stated that she is not aware of side effects of medications and there is a lot of pills going out. On 5/25/16 at 9:40 a.m., Staff G, Licensed Practical Nurse (LPN) was interviewed and stated she recalled on 5/2/16 pulling Staff EE from the floor to administer medications as the facility short was staffed and she went to the dining room to assist with the meal service. Staff G stated she did not recall giving Resident #1 the 2 p.m. scheduled dose of Sinemet and that Staff EE had signed out on the Medication Administration Record (MAR) as administering the 2 p.m. dose. Staff G stated she would not administer the 2 p.m. Sinemet dose at 5 p.m., she would have	F 329	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 329	Continued From page 70 completed a medication error form, assess the resident, notify the resident ' s physician and family and document it. Staff G stated Staff EE never asked her about administering the resident ' s Sinemet nor did Staff EE report anything about doubling up on the resident ' s 2 p.m. and 6 p.m. dose of Sinemet. Staff G stated she received a phone call at 5:26 p.m. from the hospital on-call nurse regarding the resident and Staff G stated she went to the resident ' s room, no call light on, and resident on the floor having a seizure. Staff G stated she assessed the resident and called the resident ' s physician and order received to send resident to the emergency room for further evaluation, and resident was immediately transferred via ambulance. Staff G stated she looked at the resident ' s phone and noted the resident had called the on-call nurse at 5:04 or 5:06 p.m. On 5/25/16 at 3:30 p.m., the Pharmacist was interviewed and stated Sinemet has a long list of side effects and people who take this medication can build up a tolerance. The Pharmacist stated it would be difficult to relate the double dose of Sinemet to the resident ' s seizure. Review of Resident ' s #1 clinical record lacked indication a medication error occurred, that Staff EE notified facility that she administered a back to back, 2 p.m. and 5 p.m. dose of Sinemet, resident being monitored after the double dose of Sinemet, and that the resident ' s physician notified of it. 2. Resident #8 had a MDS (Minimum Data Set) dated 5/9/16. The MDS listed a diagnosis for Resident #8 of non-Alzheimer's dementia. The	F 329	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 329	Continued From page 71 MDS stated the resident required the assistance of 1-2 staff for bed mobility, transfers, walking, dressing, eating, toilet use, personal hygiene, and bathing. The MDS indicated the resident had continuous disorganized thinking and inattention and stated the resident had trouble concentrating on things and was short-tempered nearly every day of the MDS review period. The MDS indicated the resident had physical behavioral symptoms directed toward others daily and had verbal behavioral symptoms directed toward others 4-6 days out of the week. The MDS listed the resident's cognition as severely impaired. The June Physician's Order Sheet for Resident #8 displayed the following orders: a. Haloperidol(an anti-psychotic medication) 5 mg(milligrams/ml(milliliter) and to inject 0.2 ml IM(intramuscularly) every 1 hour prn(as needed) for acute agitation b. Lorazepam(an anti-anxiety medication) 1 mg Take 1 tablet every 6 hours prn for anxiety Resident #8's Medication Administration Records (MAR) for May 2016-June 2016 identified staff administered the prn Haloperidol 10 times during the period of 5/10/16- 6/18/16. The facility lacked documentation of interventions implemented prior to administration of the medication. Resident #8's Medication Administration Records (MAR) for April 2016-June 2016 revealed staff administered the prn Lorazepam 54 times during the period of 4/26/16- 6/12/16. The facility lacked documentation of interventions implemented prior to the administration of the medication. The Care Plan for Resident #8, dated 5/10/16, directed staff to call the resident's family to come visit or talk on the phone with the resident when	F 329	Please see attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 329	Continued From page 72 he/she "won't settle". The Care Plan directed staff to: Intervene before agitation escalated, guide the resident away from the source of distress, engage calmly in conversation, and, if the resident's response was aggressive, walk away calmly and approach later. During an interview on 6/22/16 at 5:55 p.m., the MDS Coordinator stated nurses should document non-pharmacological interventions on the resident's behavior sheet or in the progress notes prior to administering anti-anxiety medications.	F 329	Please See attached	7-26-16
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the	F 334	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 334	Continued From page 73 influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that – (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 334	Continued From page 74 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to administer pneumococcal vaccines to 3 of 9 residents reviewed for immunization status(Resident's #1, #6 and #7), failed to administer the Shingles vaccine (herpes zoster) as ordered by the physician for 1 resident (Resident #6), and failed to administer a tuberculosis skin test as required upon facility admission for Resident #7. The facility reported a census of 60 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 5/6/16 revealed Resident #6 had diagnoses that included non-Alzheimer's dementia, had severe cognitive impairment with symptoms of delirium, required extensive assistance by 2 or more staff members for transfers to and from bed or chair, bathing, toileting, dressing and personal hygiene, and supervision with set-up assistance required for eating, and daily verbal behaviors directed at others. A physician order dated 12/31/15 directed staff: 1. Assure Shingles vaccine has been given. 2. Assure Prevnar 13 (pneumococcal vaccine) is given 6 to 12 months later. Resident #6's record did not reveal documentation the resident received either vaccine. During an interview on 6/22/16 at 3:40 p.m., the	F 334	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 334	Continued From page 75 MDS coordinator nurse stated Resident #6 had not received either vaccine, and the facility had recently obtained a verbal consent from the responsible party over the phone to administer the Shingles vaccine. The facility failed to provide a copy of the Shingles vaccination information provided to the resident's responsible party. The Shingles vaccine is prepared from the live Chicken Pox virus and poses a threat for transmission of the virus (unlike most vaccines that are prepared from killed viruses and do not pose a risk for transmission of the illness). 2. The MDS dated 5/10/16 revealed Resident #7 admitted to the facility on 11/19/15 from an acute care hospital, had diagnoses that included anemia, hypertension (high blood pressure), non-Alzheimer's dementia and hip fracture, severe cognitive impairment with symptoms of delirium, and required extensive assistance of 2 or more staff members for transfers to and from bed and chair, bathing, dressing, toileting and personal hygiene, the resident had not received the pneumococcal vaccine and the vaccine not offered at the facility. The initial hospital transfer form with facility admission orders dated 11/19/15 directed staff to administer the influenza and pneumococcal vaccines. Resident #7's record did not reveal administration of the tuberculin skin test or documentation related to pneumococcal vaccine administration. The resident received the influenza vaccine prior to facility admission.	F 334	Please see attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 334	Continued From page 76 A Vaccination of Residents policy, revised April, 2013, directed staff: 1. All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated. 2. Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations. 3. Provision of such education shall be documented in the resident's record. 4. All new residents shall be assessed for current vaccination status upon admission. 5. Certain vaccines, such as influenza and pneumococcal vaccines may be administered per the physician-approved facility protocol (standing orders) after assessed by the physician for medical contraindications. A Pneumococcal Vaccine policy, revised April, 2013, directed staff: 1. All residents will be offered the pneumococcal vaccine. 2. Prior to or upon admission, residents will be assessed for eligibility to receive the vaccine, and when indicated, will be offered the vaccine within thirty days of admission to the facility unless medically contraindicated. 3. Assessments of pneumococcal vaccination status will be conducted within 5 working days of admission. 4. Before receiving the pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the vaccine. During an interview on 6/22/16 at 11:18 a.m., the	F 334	Please see attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 334	Continued From page 77 MDS coordinator nurse stated it was a standing physician admission order to administer the tuberculin skin test to all residents on admission, Resident #7 had not received the required tuberculin skin test or the pneumococcal vaccine, Staff G, Licensed Practical Nurse (LPN), was supposed to administer pneumococcal vaccines and tuberculin skin tests to residents as required but had not performed the activity, the facility aware that residents had not received tuberculin skin tests and pneumococcal vaccines as ordered. During an interview on 6/23/16 at 11:10 a.m., the MDS coordinator nurse stated the facility could not indefinitely maintain a supply of Prevnar (pneumococcal vaccine) and Staff G had not administered pneumonia vaccines to residents whom should have received it. 3. The MDS dated 4/14/16 for Resident#1 documented the resident with intact memory. The MDS revealed that the resident required extensive assistance of two staff members for bathing, and had bilateral lower extremity weakness. The MDS documented that the resident had Parkinson's disease, a seizure disorder, and heart failure.. The Physician's Order with the signed date 4/13/16 directed staff to provide the resident with the pneumococcal, and annual flu vaccinations per the facility policy. Upon record review the residents record lacked documentation of the flu or pneumococcal vaccinations being administered. During an interview on 6/22/16 the MDS	F 334	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 334	Continued From page 78 Coordinator reported that she could not find documentation of the resident's vaccinations.	F 334	Please See attached	8-17-16
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to 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. 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: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) 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 observation, individual resident interview with Resident #9 and resident group interview which included 6 residents, the facility failed to promptly answer call lights. The facility reported a census of 60 residents. Findings include:	F 353	Please See attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 353	Continued From page 79 1. During the resident group interview on 6/21/16 at 1:48 p.m. 6 of 6 residents reported that call lights can take up to 2-3 hours to get answered, and sometimes staff will shut off the light, and not come back. All the residents reported that they either had watches or clocks to keep time. 2. During observation on 6/21/16 at 2:35 p.m. a call light went on for room number 103. With constant observation a staff member responded to the call light at 2:53 p.m. 3. The Minimum Data Set (MDS) assessment tool, dated 5/12/16, listed diagnoses for Resident #9 which included cerebrovascular accident (stroke) and diabetes mellitus. The MDS indicated the resident required extensive assistance of 2 staff for bed mobility, dressing, and personal hygiene, and totally depended on 2 staff for transfers, toilet use, and bathing. The MDS listed the resident's BIMS (Brief Interview for Mental Status) score as 9 out of 15, indicating moderately impaired cognition. The care plan for Resident #9, revised 4/25/16, stated the resident required assistance from staff for bathing/showering and perineal cares. The facility Call Light policy, dated 5/21/15, directed staff to respond to call lights in a timely manner to rule out an emergency situation and to improve resident satisfaction. During an interview on 6/21/16 at 6:34 a.m., Resident #9 stated he/she has had to wait longer than 15 minutes for staff to answer his/her call light. The resident stated this happened as recently as the night before last. The resident stated he/she has had incontinence episodes due to waiting so long for staff to answer the call light.	F 353	Please see attached	8-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165463	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 353	Continued From page 80 The resident stated this makes him/her feel "like a low life". During an interview with the Director of Nursing on 6/22/16 at 5:08 p.m., she stated staff should answer call lights within 15 minutes.	F 353	Please See attached	8-17-16
F 356 SS=F	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 356	Continued From page 81 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to post the total number and actual hours worked by staff on a daily basis as required. The facility reported a census of 60 residents. Findings include: Observation on 6/20/16 at 1:07 p.m. revealed a staff posting, dated 6/8/16, posted on a bulletin board behind the Station 1 nurses station and not accessible to residents or visitors. The 6/8/16 posting identified a census of 59 residents. The posting remained without change at the following observed dates/times: 6/20/16 at 3:14 p.m. and 4:34 p.m. 6/21/16 at 6:11 a.m., 8:47 a.m., 11:09 a.m. and 4:08 p.m. 6/22/16 at 5:53 a.m. On 6/22/16 at 11:03 a.m., a staff posting dated 6/22/16 was posted on top of the 6/8/16 posting at the same location, with census of 58 identified. On 6/23/16 at 10:20 a.m., the 6/22/16 staff posting remained posted without update. During an interview on 6/23/16 at 10:20 a.m., the Director of Nursing stated the night shift nurse was responsible for the daily staff posting, and not aware there was not an updated staff posting between 6/8/16 and 6/22/16, and relocated the posting to a bulletin board in the common hallway across from the nurses station.	F 356	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 356	Continued From page 82 During an interview on 6/23/16 at 10:21 a.m., the Administrator stated she would get a frame for the posting that would be located below the clock near the Station 1 nurses station and expected staff to update the form daily as required.	F 356	Please see attached	7-26-16
F 362 SS=E	483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and resident interviews, the facility failed to provide meals in a timely manner for 2 of 2 meals observed. The facility reported a census of 60 residents. Findings include: During the resident group interview on 6/20/16 at 1:48 p.m. 6 of 6 residents reported that the meals are not on time. The residents reported that breakfast is to be served at 7:00 a.m., lunch at 11:00 a.m., and dinner at 5:00 p.m., but they are at least an hour late. Three of 3 residents who received room trays reported that room trays can be as much as two hours late. The dietician signed an alternate menu for lunch dated 6/22/16 which included ham and cheese sandwiches, macaroni and cheese, fruit, and wax beans.	F 362	Please see attached	8-17-16

PRINTED: 06/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 362	Continued From page 83 Observation on 6/22/16 at 11:25 a.m. revealed the main dining room full of residents ready for lunch. Observation on 6/22/16 at 12:00 p.m. revealed no food served to the residents. Observation on 6/22/16 at 12:15 p.m. revealed Staff C, Cook, stirred boiling macaroni on the stove. During an interview on 6/22/16 at 12:15 p.m. Staff C reported the elbow macaroni had been for the macaroni and cheese for lunch. Observation on 6/22/16 at 12:39 p.m. revealed all the residents served except those that requested macaroni and cheese, and those with room trays, and the CCDI unit. Observation on 6/22/16 at 12:43 p.m. revealed the dietary staff started to served macaroni and cheese.. Observation on 6/22/16 at 1:33 p.m. revealed the Staff FF, Registered Nurse, verbalized to the dietary staff with which residents were in the CCDI (Chronic Confusion/Dementing Illness) unit of the facility. Observation on 6/22/16 at 1:55 p.m. revealed the CCDI dining unit cart left the kitchen for distribution to the residents in the CCDI unit. Observation on 6/22/16 at 2:05 p.m. revealed the room trays delivered to the floor. Observation on 6/22/16 revealed that the last dinner tray served at 7:30 pm.	F 362	Pleas See attached	7-17-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 362	Continued From page 84 During an interview on 6/22/16 at 3:30 p.m. the Director of Nursing reported that breakfast is to be served at 7:00 a.m., lunch at 11:00 a.m., and dinner is served at 5:00 p.m..	F 362	Please See attached	7-26-16
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to provide palatable food for 1 of 1 noon meal service observed. The facility reported a census of 60 residents. Findings include: Observation on 6/22/16 at 2:00 pm revealed the following food temperatures after completion of the lunch meal service failed to be maintained at 140 Fahrenheit (F): Waxed beans: 118 degrees F, little smokies: 110 degrees F, and mac and cheese: 132 degrees F. Review of the facility policy, Safe Food Preparation, Steamtable, revealed the policy directed staff that hot foods must be 135 degrees or higher and may not stay in the steamtable for more than 30 minutes. During an interview on 6/21/16 the Dietician Consultant reported that the kitchen lacks leadership. During an interview on 6/21/16 at 6:45 a.m. Staff D, Cook, reported that he/she did not receive any	F 364	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	691 E POLK ST WASHINGTON, IA 52353

(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 364	Continued From page 85 dietary training. During an interview on 6/22/16 at 2:45 p.m. the MDS Coordinator reported that the kitchen staff didn't have dietary training.	F 364	Please See attached	7-26-16
F 371 SS=F	483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of the facility policy/procedures, the facility failed to prepare; distribute; and serve food under sanitary conditions and failed to check food temperatures after the puree process for 3 of 3 residents and prior to the service of lunch and dinner for 57 residents. The facility reported a census of 60 residents. Findings include: Observation on 6/22/16 at 12 pm identified Staff Y, cook, and began to serve food. Three plates of waxed beans were set without temperature of all food being checked on the steamtable. The surveyor prompted Staff Y to check the temperatures of all food being served. Observation on 6/22/16 at 12:45 pm identified Staff Y, cook, cutting the meat and cheese sandwiches while wearing gloves. Staff Y, with	F 371	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 371	Continued From page 86 gloves on, then touch his uniform and the resident ' s paper meal order and then returned to cutting meat and cheese sandwiches. This occurred 3 times. Observation on 6/22/16 at 1:00 pm revealed the MDS coordinator came into the kitchen to help serve sandwiches. The staff person walked in put a hair net on, donned gloves then preceded to handle meat and cheese sandwiches without washing her hands. Observation on 6/22/16 at 1:45 pm revealed Staff Y, cook, obtained the trays ready for the residents with pureed diets. Macaroni and cheese, smokies, and waxed beans pureed per guidelines and placed on service tray. Staff Y did not check the temperatures of the 3 items before serving them to 3 of 3 residents that required pureed diets. Observation on 6/22/16 at 1:52 pm revealed Staff Y go to the handwashing sink in the kitchen and placed soap on his right hand. Staff Y went to turn the water on and it would not turn on. Staff Y then went to sink at the dishwashing area and the water would not turn on. Maintenance staff had turned the water off due to handwashing sink leaking out of the collection buckets on to the floor. Staff Y then took a paper towel; wiped soap out of right hand, donned gloves then proceeded with meal service. Observation on 6/22/16 at 2:00 pm revealed Staff C, Cook, cut meat and cheese sandwiches with gloves on, putting the sandwiches on room and unit trays, placed a lid on the plate then back to cutting meat and cheese sandwiches. This took place five (5) times. Observation on 6/22/16 at the service of lunch and dinner revealed the dietician and the administrator wearing open toed shoes. The dietician wore black ¾ heeled shoes with one	F 371	Please see attached	7-26-16

PRINTED: 06/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 371	Continued From page 87 strap across the base of toes with another strap below it. The dietician helped prepare and serve food multiple times. The administrator wore wedges with a thick strap at the base of toes. The administrator helped wash dishes and in the food preparation and service area multiple times. Observation on 6/22/16 at 5:30 pm revealed the surveyor needed to prompt Staff Z, cook, to check the temperatures of all food prior to serving the dinner meal. Review of the facility policy/procedure titled, Safe Food Preparation, directed staff to obtain final cooking temperatures; foods must reach the following internal temperatures for a minimum of fifteen seconds, sanitizing your thermometer as you move from one food item to the next. The policy directed staff to achieve the following temperatures; meats 165 degrees Fahrenheit; fresh, frozen or canned fruit and vegetables 165 degrees Fahrenheit; poultry and stuffed foods 165 degrees Fahrenheit. During an interview on 6/21/16 the Dietician Consultant reported the kitchen lacked leadership. During an interview on 6/21/16 at 6:45 a.m. Staff D, Cook, reported she did not receive any dietary training. During an interview on 6/22/16 at 2:45 p.m. the MDS Coordinator reported the kitchen staff did not have dietary training. During the initial kitchen tour on 6/20/16 at 9:30 a.m. to 10:12 a.m., identified the following concerns: the walk-in-refrigerator contained a large roast beef cooked in a 4 quart plastic container not sealed, labeled or dated, a 1.75 pound package of pepperoni, not sealed or dated, a 4 quart container of ham slices not sealed or dated, a 22.4 pound box of Farmland meat directly on the floor, 18 ham and cheese	F 371	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 371	Continued From page 88 sandwiches on a cookie sheet not covered or dated, a box of 15 dozen pasteurized eggs directly on the floor, a 5 pound plastic bag of mozzarella cheese half full and unsealed nor dated. The walk-in-refrigerator floor contained a moderate amount of food debris to include shredded carrots, cheese, and butter packets. The kitchen work area contained a 22 quart plastic container full of flour, with a one cup measuring cup in the flour directly on the floor. A white three-tiered plastic food cart, contained a moderate amount of food debris. The kitchen floor in the prep area, under the sink, and under the dishwasher contained the following items; silverware, food debris, a plastic orange glass under the dishwasher. The entire kitchen floor had a sticky surface. Under the handwashing sink, contained 2 four inch by four inch cracked white floor tiles. The blue-green colored tile under the food prep table contained several cracked tile of various sizes. The countertops in the kitchen contained a cloudy appearance, the metal prep table contained a gritty surface with food debris. There were no sanitizer buckets in the kitchen. The meat slicer had a cloudy film on it with food debris, it was not being used and was uncovered. Both Vulcan ovens had a moderate amount of carbon build up inside, and the outer doors contained a greasy surface with food drippings. The griddle to the stove contained grease build up. The backsplash of the stove contain a heavy carbon build up. The shelf above the ovens contained a greasy, fuzzy surface. Above steamtable contained an air vent with black fuzzy debris. The front of the white cupboards in the kitchen contained a gummy surface with a moderate amount of food debris. The milk cooler contained 27 4 ounce undated thawed containers	F 371	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 371	Continued From page 89 of strawberry Mighty shakes, and 40 4 ounce undated thawed containers of chocolate Mighty shakes. During an interview on 6/20/16 at 9:45 a.m. Staff D, Cook reported that she did not know how long the Mighty shakes had been in the cooler. The dry storage area revealed boxes directly on the floor which included, a 50 pound box of potatoes, box or 6- 6 pound cans of Crisco, a box with 24 cans of unpeeled diced red peppers, and 6 emply cardboard boxes. The dry storage floor contained a thin layer of dried mud, with a sticky film. The walk-in-freezer revealed the following items directly on the floor; 30 pound box of tater tots, a box of 6- 3 pound bags of blueberries, a 30 pound box of french fries, 2- 3 gallon drums of vanilla ice cream. The service hallway between the dry storage, and kitchen entrance revealed a floor coated with a thin layer of dirt. There were no cleaning schedules posted in the kitchen area, and no notebooks could be found either. Observation on 6/21/16 at 10:15 a.m. revealed the kitchen, service hallway floor, walk-in-freezer, walk-in-refrigerator, appeared same as the initial tour, and no cleaning schedules were found. Observation on 6/21/16 at 1:30 p.m. revealed concerns from the initial kitchen tour remain the same, and the walk-in-refrigerator also now included a 4 quart container half full of beets without a date.	F 371	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 371	Continued From page 90 Observation on 6/21/16 at 3:24 p.m. revealed initial kitchen tour concerns remained the same. The Facility Cleaning and Sanitizing Policy documented the following: Surfaces are to be washed, rinsed and sanitized after each use, and following any interruption of operations when contamination may have occurred. The food-contact surfaces of grills, griddles and similar cooking devices, and the cavities and door seals of microwave ovens are to be cleaned at least once a day. Food-contact surfaces of all cooking equipment are to be kept free of encrusted grease deposits and other accumulated soil. All work surfaces are to be cleaned, and sanitized after each use; clean-as-you-go. The Food Storage Policy documented the following: Food removed from it's original packaging is to be protected from contamination, by storing in clean, covered, sanitized containers. Food containers are to be stored a minimum of 6 inches above the floor to protect food from splash, contamination, and at a height to prevent easy cleaning of the storage area. All items are to be 6 inches off the floor, including all cardboard boxes. The facility policy for Safe Food Preparation documented that the facility will monitor and control the safe preparation of all foodstuff, including potentially hazardous food, to prevent food-borne illness. The policy directed supervisors, as well as staff member, will be expected to check the concentration of sanitizer and the cleanliness of the solution. Work surfaces and equipment will be cleaned with detergent and sanitized between uses. Gloved hands are considered to be a food contact	F 371	Please see attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 371	Continued From page 91 surface that can become contaminated or scolded. Failure to change gloves between tasks contributes to cross-contamination. Disposable gloves are single use items and must be disposed of after each use. During an interview on 6/21/16 at 6:45 a.m. Staff B, Staff C, and Staff D all cooks reported that they have tried to call the Dietary Supervisor, but he will not answer. The staff reported that the Dietary Supervisor had been at the facility for a month. During an interview on 6/21/16 at 10:11 a.m. the Administrator reported that they had not been able to get a hold of the Dietary Supervisor, and that different staff members have tried to call him. During an interview on 6/21/16 at 4:00 p.m. the facility Dietician Consultant reported that nobody had been able to get in contact with the dietary supervisor. The Dietician reported that she had been working with the current staff, and the dietary staff has a lot to learn. The Dietician reported staff are hard to keep. The Dietician reported she had been under part-time employment with the facility since December. The Dietician had been working with the dietary staff with education related to meal substitutions, the pureed process, and how to organize meal service so it has an organized system. The Dietician reported the kitchen lacked leadership. A continuous observation on 6/21/16 between 8:36 a.m. and 11:09 a.m. identified the staff did not sanitize the dining room tables after the conclusion of the breakfast meal and before the lunch meal was served. On 6/21/16 at 10:51 a.m., Staff D, cook, placed paper placemats on	F 371	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 371	Continued From page 92 the dining room tables and over wet water rings that remained from breakfast beverages. Plated lunch meals were placed on top of the placemats. During an interview on 6/22/16 at 7:13 p.m., the facility's registered and licensed dietician (RDLD) stated a sanitizer was available in the kitchen and staff should sanitize the dining room tables between each meal service.	F 371	Please see attached	7-17-16
0 F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	Please see attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 441	Continued From page 93 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to carry out adequate infection control measures for 2 of 2 residents utilizing a glucometer (Residents # 22 and #23) and failed to properly dispose of soiled linens for 1 of 9 residents observed during personal cares (Resident #4). The facility reported a census of 60 residents. Findings include: 1. The Admission record for Resident #22 listed a diagnosis of diabetes mellitus. During an observation on 6/21/16 at 7:02 a.m., Staff G, Licensed Practical Nurse (LPN) obtained a blood sample with the glucometer for Resident #22 to check the resident's blood sugar level. After completing the blood sugar check, Staff G wiped the glucometer off with a Sani-cloth. Staff G did not leave the Sani-cloth in contact with the glucometer for any measurable period of time. 2. The Admission record for Resident #23 listed a diagnosis of diabetes mellitus.	F 441	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 441	Continued From page 94 During an observation on 6/21/16 at 6:58 a.m., Staff G, LPN, obtained a blood sample with the glucometer for Resident #23 to check the resident's blood sugar level. After completing the blood sugar check, Staff G wiped the glucometer off with a Sani-cloth. Staff G did not leave the Sani-cloth in contact with the glucometer for any measurable period of time. Staff G utilized the same glucometer for Residents #22 and #23. During an interview on 6/22/16 at 5:00 p.m., the Director of Nursing stated staff should cleanse the glucometers with an alcohol wipe and leave the wipe in contact with the glucometer for 2 minutes. 3. Observation on 6/20/16 at 12:20 pm revealed urine saturated linens: disposable incontinence pad, fitted sheet, and cover sheet on Resident #4's floor near the resident's room door. The room contained light to dark yellow stains visible on the linens on the floor. The resident's room also contained a strong urine odor smell. 4. Observation on 6/21/16 at 8:20 am revealed urine saturated linens: disposable bed pad and one white sock on Resident #4's floor by the entrance to the resident's room. The room contained light to dark yellow stains visible on the linens. The room contained a strong urine odor smell over the linens. During an interview on 6/22/16 at 10:15am Staff V, Housekeeper, reported staff are to dispose of dirty linen. Staff V indicated when he/she is cleaning and sees dirty linen on the floor, he/she will bag them, place them in the appropriate place, and spray disinfected on the area then pat it dry. When asked how the carpet in resident's rooms are cleaned after spills or when dirty linen	F 441	Please see attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 441	Continued From page 95 has been left on the floor Staff V reported that if it is a large area the facility has 2 carpet shampooers that will be used. If it is a smaller spot, it can be cleaned by hand. During an interview on 6/22/16 at 9:30am the Staff Development Coordinator reported, audits are completed twice a week to ensure peri-care, bathing and other ADLs are being completed per guidelines. The Staff Development Coordinator reported that if issues are noted, the staff is corrected at the time an issue is noted and offered on the spot training.	F 441	Please See attached	7-26-16
F 467 SS=E	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure adequate odor control throughout the facility. The facility identified a census of 60 residents. Findings include: 1. Observation upon initial tour on 6/20/16 at 10:30 a.m. revealed a strong smell of urine in the specialized behavioral unit near the nursing station. 2. Observation on 6/20/16 at 10:45 a.m. revealed a strong smell of urine in the hallway of the 600 Hall.	F 467	Please See attached	7-26-16

PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 467	Continued From page 96 3. Observation on 6/21/16 at 6:30 a.m. revealed a strong smell of urine in the specialized behavioral unit near the nursing station. 4. Observation on 6/21/16 at approximately 2:00 p.m. revealed a strong smell of urine in the hallway of the 600 Hall. 5. Observation on 6/22/16 at approximately 12:00 p.m. revealed a strong smell of urine in the hallway of the 600 Hall. During an interview on 6/21/16 at 6:30 a.m., Staff N, Certified Nursing Assistant, acknowledged the unit smelled like urine and stated it might be due to the trash which staff had not taken out yet. During an interview on 6/22/16 at 5:08 p.m., the Director of Nursing acknowledged she had smelled urine in the 600 Hall. She stated there was a heavily incontinent resident in the hall and the facility planned to move him/her to a room with tile rather than carpet. 6. Observation on 6/20/16 at 12:20 pm revealed a strong urine odor in Resident #4's room. Resident's room smelled of old urine. Upon walking into Resident #4's room noted urine saturated linens: disposable bed pad, fitted sheet, and cover sheet on Resident #4's floor by entry door. Light to dark yellow stains visible on the linens that were on the floor. A strong urine odor smell hovered over the linens. The Resident stated the recliner is wet with urine. Resident #4's room felt humid, air conditioner not on, the personal fan had been on facing the resident, and the resident requested the door to be closed prior to leaving. 7. Observation on 6/21/16 at 8:20 am revealed	F 467	Please see attached	7-26-16

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

PRINTED: 08/05/2016
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
	165453	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(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 467	Continued From page 97 Resident #4 sat in the recliner. The room smelled of urine. Noted urine saturated linens: chux pad and one white sock on Resident #4's floor by entry door. Light to dark yellow stains visible on the linens were on the floor. A strong urine odor smell hovered over the linens. 8. Observation on 6/21/16 at 9:00 am revealed very strong urine, almost ammonia like, smell coming from Resident #4's hunter green recliner in resident's room. Observed Staff S, Certified Nurse Aide, placed a disposable bed pad on the recliner before the resident sat down. 9. Observation on 6/22/16 at 7:30 pm revealed Resident #4's room smelled a little better, but still smelled of urine. During an interview on 6/22/16 at 10:15 a.m. Staff V, Housekeeper, reported staff are to dispose of dirty linen. Staff V indicated when he/she is cleaning and sees dirty linen on the floor, he/she will bag them, place them in the appropriate place, and spray disinfected on the area then pat it dry. When asked how the carpet in resident's rooms are cleaned after spills or when dirty linen had been left on the floor Staff V reported that if it is a large area the facility has 2 carpet shampooers that will be used. If it is a smaller spot, it can be cleaned by hand.	F 467	Please See Attached	7/26/16

PRINTED: 07/25/2016
FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0948	A. BUILDING: _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CI	601 E POLK ST WASHINGTON, IA 52353

(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) COMPLETE DATE
L1093	58.12(1)I Admission, transfer, and discharge 58.12(135C) Admission, transfer, and discharge. 58.12(1) General admission policies. I. For all residents residing in a health care facility receiving reimburaement through the medical assistance program under Iowa Code chapter 249A on July 1, 2003, and all others subsequently admitted, the facility shall collect and report information regarding the resident's eligibility or potential eligibility for benefits through the Federal Department of Veterans Affairs as requested by the Iowa commission on Veterans Affairs. The facility shall collect and report the information on forms and by the procedures prescribed by the Iowa commissions on veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services. In the event that a resident is unable to assist the facility in obtaining the information, the facility shall seek the requested information from the resident's family members or responsible party. For all new admissions, the facility shall collect and report the required information regarding the resident's eligibility or potential eligibility to the Iowa commission on veterans affairs within 30 days of the resident's admission. For residents residing in the facility as of July 1, 2003, and prior to May 5, 2004, the facility shall collect and report the required information regarding the resident' s eligibility or potential eligibility to the Iowa commission on veterans affairs within 90 days after May 5, 2004. If a resident is eligible for benefits through the federal Department of Affairs or other third-party payor, the facility shall seek reimbursement from such benefits to the maximum extent available before seeking reimbursement from the medical	L1093	please see attached	8-17-16

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Candace Gilton
TITLE: Administrater
(X6) DATE: 8-4-16

STATE FORM 6899 0JLG11 If continuation sheet 1 of 3

PRINTED: 07/25/2016
FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0948	A. BUILDING: _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CI	601 E POLK ST WASHINGTON, IA 52353

(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) COMPLETE DATE
L1093	Continued From page 1 assistance program established under Iowa Code chapter 249A. The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care or to the admission of an individual to the Iowa Veterans Home. (II,III) This Statute is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that residents eligible for veteran benefits were entered on the facility's Current Resident Summary (CRS form) report for 3 of 5 resident records reviewed (Residents #15, #19 and #20). The facility reported a census of 60 residents. Findings include: Review of the facility's Resident Admission Reports and CRS report revealed: 1. Resident #15 was admitted to the facility on 11/20/15, remained at the facility until 5/30/16, and was not assessed for veteran benefits eligibility. 2. Resident #19 was admitted to the facility on 3/22/16, remained at the facility at the time of survey completion on 6/23/16, and was not assessed for veteran benefits eligibility. 3. Resident #20 was admitted to the facility on 1/11/16/16, remained at the facility at the time of survey completion on 6/23/16, and was not assessed for veteran benefits eligibility. During an interview on 6/23/16 at 10:50 a.m., the Administrator stated the previous administrator	L1093	Please see attached	

PRINTED: 07/25/2016
FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0946	A. BUILDING: _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CI	601 E POLK ST WASHINGTON, IA 52353

(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) COMPLETE DATE
L1093	Continued From page 2 was responsible for resident veteran benefit eligibility assessment, unable to locate the records for Resident's #15, #19 and #20, and messages left that requested return calls from the previous administrator had gone unanswered.	L1093	Please see attached	

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F157

I. Following corrected action will be accomplished for those residents found to have ineffective by the current practice.

- Resident was discharged from facility on 6/12/16.
- Any changes in residents condition injury or any med changes, cardex orders must be reported to doctor immediately, Director of Nursing and Administrator

II. Other residents with the potential to be affected by the current practice: Will be identified and the following corrective actions will be taken.

- Director of Nursing or designee has reviewed all incident and accident reports for past 30 days to assure all/any changes.
- Family notified of changes in condition or any other conditions.
- Director of Nursing or designee has reviewed all 24-hour reports and nurses note to assure notification of change.

III. Following measures will be put in place/and or systemic changes will be made to ensure the current practice does not reoccur.

- Full assessment from nurse
- Staff to be re-educated on policy of change of residents condition by Director of Nursing or Designee.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Director of Nursing have developed an audit tool to monitor compliance.
- The Director of Nursing or designee will complete this audit daily for one month. Then the Director of Nursing or designee will audit weekly for 6 months per QI Committees recommendations.
- Any findings will be reported to the Administrator immediately.
- All findings shall be reported to the QI Committee monthly for further recommendation and action.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F167

I. Following elements were implemented to correct the deficiency

- The survey book will be posted by the front door.

II. The Administrator or designee completed a survey book inspection.

III. Following measures will be put in place/and or systemic changes will be made to ensure the current practice does not reoccur.

- Administrator or designee will file newest survey report

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator or designee have developed an audit tool to monitor compliance.
- The Administrator or designee will complete this audit weekly for one month. Then the Administrator or designee will audit monthly for 6 months per QI Committees recommendations.
- All findings shall be reported to the QI Committee monthly for further recommendation and action.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F208

I. Following corrected action will be accomplished for those residents found to have ineffective by current practice.

- Resident #1 has been given the admission information by the social service coordinator on 8/5/2016.

II. Other residents with the potential to be affected by the current practice will be identified and the following corrective actions will be taken.

- To identify other residents that may be affected, the DON or designee have reviewed all residents to assure all admission paperwork was completed. Any residents affected found deficient will have paperwork completed immediately.

III. The following measures will be put in place and/or systemic changes will be made to ensure the current practice does not reoccur.

- DON or designee will monitor all new admission paperwork for compliance.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Director of Nursing have developed an audit tool to monitor facilities compliance with plan of correction.
- The Director of Nursing or designee will be responsible for the audit completion.
- Any negative finding will be reported immediately to the Administrator for follow up.
- Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F225

I. Following corrected action will be accomplished for those residents found to have ineffective by the current practice.

- Investigate/report allegation immediately
- There as been no further incidents involving resident #8 and #21.
- Administrator or designee will report all new hires have proper paper work completed before allowing them to work in facility.

II. Other residents with the potential to be affected by the current practice; will be identified and the following corrective actions will be taken.

- Director of Nursing or designee has reviewed 30 days of all documented incident and accident reports including but not limited to resident-to-resident altercations.
- Any identified will be reported to DIA
- No others have been identified during review

III. Following measures will be put in place/and or systemic changes will be made to ensure the current practice does not reoccur.

- All incidents/accident reports will be reviewed during faculties daily review to determine if incident meet reportable standards
- Any resident-to-resident altercation during weekend will immediately be reported to Director of Nursing or designee for assessment and review if occurrence meets reportable standard.
- If it is determined that incident rises to reportable, the facility Administrator will immediately be notified.
- All staff will be re-educated on Resident Safety, incident reporting and Reportable Criteria,

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator Director of Nursing has developed an audit tool to monitor compliance.
- The Director of Nursing or designee will complete this audit weekly for one month. Then the Director of Nursing or designee will audit monthly for 6 months per QI Committees recommendations.
- All findings shall be reported to the Administrator immediately and to the QI Committee monthly for further recommendation and action.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F246

I. Following corrected action will be accomplished for those residents found to have ineffective by the current practice.

- Resident 6 & 7 will have all scheduled meals provided in special needs dining room.
- Resident 1 received the recommended Botox on 6/29/16.
- Resident 2 was seen by vascular on 7/11/16 and no follow up recommendation
- Resident 12 doctor's office notified to schedule appointment with neurologist. Awaiting return call.

II. To determine if other residents may have been affected

- Director or Nursing or designee have reviewed and audited all consult orders and recommendations to determine if residents have ordered consultative doctor follow up for the previous 3 months.
- Director of Nursing or designee have reviewed residents feeding plan of care. Based on record review and direct observation residents identified have been referred to speech therapy for evaluation. All plans of care have been revised accordingly.
- Director of Nursing and Administrator have developed a dining room assignment for staff, to provide residents with assistance according to residents individual plan of care.
- Resident care cardex have been audited by Director of Nursing or designee to assure that all areas are reflected. Any area identified lacking on cardex was corrected immediately at time of audit.

III. Following measures will be put in place and /or systemic changes have been made to ensure the current practice does not reoccur.

- The Medical Records Coordinator, Director of Nursing, Administrator, Resident Care Coordination will meet daily to review all outgoing appointments, transportation schedules and any follow up recommendations as ordered/recommended.
- All appropriate staff shall be educated on new policy and procedure
- Medical Records Coordinator shall maintain an ongoing flow sheet for the purpose of logging all appointments, date ordered, transportation and date of completions as well as follow up appointments.
- The Medical Records Coordinator will copy and review with Director of Nursing all returning consults progress notes daily to assure and follow up orders/recommendations are adhered to.
- To provide increase supervision during meals the Director of Nursing or designee have assigned staff to dining room on daily bases and document staff assigned to meal service. Administrative staff will be assigned to assist and supervise dining room service and resident supervision/assistance.

- The Administrator has enhanced dining room staff supervision to include a member of the rehab department as well as designated facility staff
- MDS Coordinator shall be responsible for reviewing, updating and maintaining resident certified nursing assistant cardex and individual plans of care.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Director of Nursing have developed an audit tool to monitor facilities compliance with plan of correction.
- The Director of Nursing or designee will be responsible for the audit completion.
- Any negative finding will be reported immediately to the Administrator for follow up
- Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F252

I. Following corrected action will be accomplished for those residents found to have ineffective by the current practice.

- Resident #1's room was immediately cleaned and trash emptied.

II. Other residents with the potential to be affected by the current practice: Will be identified and the following corrective actions will be taken.

- The Director of Maintenance and Administrator completed a room-by-room inspection to identify any housekeeping deficiencies no other were identified.

III. Following measures will be put in place/and or systemic changes will be made to ensure the current practice does not reoccur.

- All resident rooms will be inspected daily by the Director of Maintenance/designee.
- All staff have been re-educated on maintaining a clean environment including but not limited to overflowing trash receptacles.
- Additional housekeeping staff have been hired, trained and scheduled.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Director of Maintenance have developed an audit tool to monitor compliance.
- The audit tool includes direct observation of all resident rooms.
- The Director of Maintenance will complete this audit daily for one month. Then the Director of Maintenance will audit weekly for 6 months per QI Committees recommendations.
- Any findings will be reported to the Administrator immediately.
- All findings shall be reported to the QI Committee monthly for further recommendation and action.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F253

I. The following interventions were implemented to correct identified area

1. A floor tech has been hired to refurbish the dining room floor.
2. The walls in the Assisted Dining Room have been cleaned by housekeeping.
3. Repairs have been made to the leaking ceiling and tiles replaced in the 300 hall soiled utility room.
4. The facility is in the process of obtaining work estimates for repairs of the wall with bulge and discoloration as identified.
5. The fenced in courtyard has been weeded and will continue to be weeded by maintenance personnel or designee.
6. The exterior door to the courtyard has been ordered will be replaced upon receipt.
7. The electrical wires sticking out of the courtyard wall have been removed by maintenance.
8. The holes inside the Memory Care Unit have been patched and painted by maintenance.
9. Resident rooms #308, 310, 311, 312, 600, 602, 603, 604, 605, 606, 607, 609, and 611 have been cleaned with the carpet extractor by housekeeping.
10. Resident rooms #604, 606 and 611 have been deep cleaned odor removed by housekeeping.

10A. Wallpaper removal and painting is ongoing and will continue throughout the facility until completed by maintenance.

11. Resident #8 toilet has been cleaned by housekeeping.
12. Resident #9 room has been cleaned and floor swept and mopped by housekeeping.

13A. The facility is in process of obtaining work estimates for repairs in the shower room on Hall 100 to replace/repair the grout in between the shower tiles identified. The vent and orange/black substance has been cleaned by housekeeping.

13B.Non-slip pads and shower mat have been ordered for the bottom of the shower room on Hall 500 and will be replaced upon receipt. The orange/black substance on the shower floor has been cleaned by housekeeping.

13C. The facility is in process of obtaining work estimates for repair/replacement of the grout in the shower room on Hall 600 identified. The shower wall covered with an orange/black substance has been cleaned by housekeeping. The baseboard near the shower with orange/black substance has been cleaned by housekeeping.

II. Other residents with the potential to be affected by the current practice: Will be identified and the following corrective actions will be taken.

- The director of Maintenance along with the Administraotr completed a room-by-room inspection to list and identify, but not limited to rooms with stained carpets, odors, sticky/dirty floors, and stained shower rooms.
- A list was compiled of all repairs needed during the inspection.
- The Director of Maintenance and Administrator developed a work list and schedule to complete all repairs.

III. Following measures will be put in place/and or systemic changes will be made to ensure the current practice does not reoccur.

- The Administrator and Director of Maintenance have developed a weekly room inspection audit tool to be completed by the Director of Maintenance or designee.
- All rooms will be inspected weekly and results of audit will be given to Administrator for review.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Director of Nursing of designee have developed an audit tool to monitor daily x 2 weeks, then weekly x 6 months.
- Any findings will be brought to the Administrator immediately.
- All findings shall be reported to the QI Committee monthly for further recommendation and action.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F254

I. Following corrected action will be accomplished for those residents found to have ineffective by current practice.

- Resident #1 and resident #3 were provided washcloths and towels immediately.
- New washcloths and towels were ordered, received and distributed on 6/27/16.

II. Other residents with the potential to be affected by the current practice will be identified and the following corrective actions will be taken.

- To identify other residents that may be affected, the Director of Maintenance or designee completed a room-by-room inspection to identify any housekeeping deficiencies no other were identified.

III. The following measures will be put in place and/or systemic changes will be made to ensure the current practice does not reoccur.

- All resident rooms will be inspected daily by the Director of Maintenance/designee.
- All staff have been re-educated on providing wash cloths and towels to all residents
- Additional washcloths and towels were ordered and received on 6/27/16.

IV. The following will be completed and monitored to the quality assurance program.

- The Director of Maintenance or designee have developed an audit tool to monitor facilities compliance with plan of correction.
- The Director of Maintenance or designee will be responsible for the audit completion.
- Any negative finding will be reported immediately to the Administrator for follow up.
- Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F279

I. Following corrected action will be accomplished for those residents found to have ineffective by the current practice.

- Resident 6 was evaluated by Psychatractive Service on 7/19/16.

II. To determine if other residents may be affected the Director of Nursing or designee have reviewed all residents feeding plan of care and by direct obvesrvation and/or interview have referred residents identified to speech therapy fore evaluation.

- Care Plans were revised accordingly.
- Don and Administrator have developed a staff dining room assignment to provide residents with assistance according to residents individual plan of care.
- Resident Care Cardex have been audited by Director of Nursing or designee to assure that all areas of care are reflected. Any resident identified as missing a cardex was provided immediately at time of audit.

III. The facility has implemented the following system changes to prevent reoccurrence.

- To provide increased supervision during meals the Director of Nursing or designee have assigned staff to dinning room on daily basis.
- In addition to assigned staff, meals will be supervised by an administrative staff member.
- The Administrator has enhanced dining room staff supervision to include a member of the rehab department as well as designated facility managers.
- MDS Coordinator shall be responsible fore reviewing, updating and maintaining residents certified nursing assistant care cardex and individual plans of care.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Director of Nursing have developed an audit tool to monitor facilities compliance with plan of correction.
- The Director of Nursing or designee will be responsible for the audit completion.
- Any negative finding will be reported immediately to the Administrator for follow up
- Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F279

I. Following corrected action will be accomplished for those residents found to have ineffective by the current practice.

- Resident 7 was evaluated by Psychatractive Service on 7/19/16.
- All staff were immediately educated on the importance of assuring resident safety and supervision including but not limited to not closing resident door or other practices that may upset staff ability to prove appropriate monitoring of residents.

II. The Director of Nursing or designee have reviewed all residents in facility with potential to be affected by residents behaviors that may result in a decrease of resident observation and safety.
- All residents identified will be reviewed by inner disciplinary committee and care plans revised as indicated.

III. The facility has implemented the following system changes to prevent reoccurrence.

- All residents identified as high risk for falls/injury will be identified with a silver star outside room.
- All staff have been educated on safety precautions associated with Silver Star.
- Resident identified room door will remain open unless staff is present in room.
- All staff passing resident room with silver staff will visually check room to assure resident safety.
- A list of those residents identified will be maintained at each nurse's station by Director of Nursing or designee.
- Certified Nurses Aide cardex have been updated to reflect Silver Star program.
- All identified residents care plan will identify safety precautions and will be updated by the MDS coordinator.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Director of Nursing have developed an audit tool to monitor facilities compliance with plan of correction.
- The Director of Nursing or designee will be responsible for the audit completion.
- Any negative finding will be reported immediately to the Administrator for follow up
- Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F279

I. Following corrected action will be accomplished for those residents found to have ineffective by the current practice.

- Resident 4 was evaluated by speech therapist on July 28, 2016 with the following recommendations.
- Resident diet changed to regular diet and may have thin liquid with no restrictions
- Resident care plan has been reviewed and revised with current speech therapist recommendations
- Resident use of paper dishes has been discharged secondary to decrease in behaviors
- Resident certified nurses assistant care cardex has been updated to reflect care needs.
- Resident 6 will be eating in assisted dining room which is more quite environment laboratory work that included a complete medical profile and pre-albumin, physician confirmed order with signature on 5/17/16 via fax.

II. The Director of Nursing or designee have reviewed all residents feeding plan of care and speech therapy evaluation orders obtained as identified.

- Director of Nursing and administrator have developed a staff dining room assignment to assure all residents are provided with assistance as identified in residents individual plan of care.
- All resident care cardex have been reviewed by Director of Nursing or designee to assure that all resident care and safety needs are reflected.

III. The facility has implemented the following system changes to prevent reoccurrence.

- To provide increased supervision during meals the Director of Nursing or designee has assigned dedicated staff to both the main dining room and the assisted dining room on a daily basis.
- The administrator has enhanced dining room supervision by including a member of the rehab department as well as designated facility members.
- MDS Coordinator shall be responsible for reviewing, updating and maintaining certified nursing assistant cardex and care plan.
- Speech therapy will continue to screen residents quarterly, change of status, and upon readmission from hospital.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Director of Nursing have developed an audit tool to monitor facilities compliance with plan of correction.
- The Director of Nursing or designee will be responsible for the audit completion.
- Any negative finding will be reported immediately to the Administrator for follow up
- Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F281

I. Following corrected action will be accomplished for those residents found to have ineffective by the current practice.

- Resident 5 G Tube was flushed and signed for by nurse

II. There are no other residents with internal feeding in the facility. Resident 5 has an appointment at the University of Iowa City for GT removal on August 3, 2016.

III. Director of Nursing or designee will review all treatment records for signature verification of completion daily. Any omissions will be brought to the attention of the nurse for review and investigated. All nurses have been educated on treatment policy and procedure including but not limited to signature/initial after completion.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Director of Nursing have developed an audit tool to monitor facilities compliance with plan of correction.
- The Director of Nursing or designee will be responsible for the audit completion.
- Any negative finding will be reported immediately to the Administrator for follow up
- Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F309

I. Following corrected action will be accomplished for those residents found to have ineffective by current practice.
- Resident #10 was discharged from facility on 6/12/16.
- Resident #27 had surgical procedures/removal of basal cell on 5/19/16. All recommendations were followed as ordered.

II. Director of Nursing or designee have reviewed all reported accidents and incidents for past 30 days as well as all nursing documentation for any injury/bruise and any change in condition not previously noted.
- The Director of Nursing or designee have reviewed and audited all consultant orders/recommendations to determines if residents were ordered/received consultative/doctor follow p for previous 3 months.

III. The following system changes have been implemented to prevent reoccurrence.
- All residents with accident and incident including resident's unidentified injury as well as those with no visible injury will be assessed by a nurse q shift x 72 hours and document results including change in condition.
- The DON or designee will maintain a flow sheet of all residents requiring 72-hour assessment post accident and incident to assure compliance.
- All appropriate staff have been educated on revised policy and procedure.
- The medical records coordinator, DON, Administrator, resident Care Coordinator will meet daily to review all outgoing appointments, transportation schedule and any follow up recommendations as ordered.
- All appropriate staff shall be educated on the new policy and procedure.
- Medical records Coordinator shall maintain an ongoing flow sheet for the purpose of recording all appointments, date ordered, transportation, date completed as well as follow-up appointments.
- The Medical Records Coordinator will copy and review with DON and Administrator all returning consults recommendation and progress notes daily to assure compliance.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Director of Nursing have developed an audit tool to monitor facilities compliance with plan of correction.
- The Director of Nursing or designee will be responsible for the audit completion.
- Any negative finding will be reported immediately to the Administrator for follow up
- Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.

Date of Completion July 26, 2016

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F312

I. Following elements were implemented to correct the deficiency as it relates to residents 1, 2,4,5,11,16,17,18.
- All received bath/shower as per bathing schedule/resident preference.

II. Director of Nursing or designee have reviewed all residents bathing schedule to assure all residents are scheduled for a bath/shower at minimum 2x/week.
- MDS Coordinator has updated certified nurses aide care cardex to reflect residents bath schedule/preference.

III. The following system changes have been implemented to prevent reoccurrence.
- Director of Nursing or designee will review all bath records including shower skin sheet daily. DON or designee will interview all residents who refuse a bath/shower to encourage/reschedule bath/shower.
- Resident care coordinator will interview all new admissions for bath preference and schedule baths accordingly.
- All nursing staff will be re-educated on resident bath documentation.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Director of Nursing have developed an audit tool to monitor facilities compliance with plan of correction.
- The Director of Nursing or designee will be responsible for the audit completion.
- Any negative finding will be reported immediately to the Administrator for follow up
- Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F323

I. Following corrected action will be accomplished for those residents found to have ineffective by the current practice.

- Resident 7 was evaluated by Psychatractive Service on 7/19/6.
- All staff were immediately educated on the importance of assuring resident safety and supervision including but not limited to not closing resident door or other practices that may upset staff ability to prove appropriate monitoring of residents.

II. The Director of Nursing or designee have reviewed all residents in facility with potential to be affected by residents behaviors that may result in a decrease of resident observation and safety.

III. The facility has implemented the following system changes to prevent reoccurrence.

- All residents identified as high risk for falls/injury will be identified with a silver star outside room.
- All staff have been educated on safety precautions associated with Silver Star.
- Resident identified room door will remain open unless staff is present in room.
- All staff passing resident room with silver staff will visually check room to assure resident safety.
- A list of those residents identified will be maintained at each nurse's station by Director of Nursing or designee.
- Certified Nurses Aide cardex have been updated to reflect Silver Star program.
- All identified residents care plan will identify safety precautions and will be updated by the MDS coordinator.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Director of Nursing have developed an audit tool to monitor facilities compliance with plan of correction.
- The Director of Nursing or designee will be responsible for the audit completion.
- Any negative finding will be reported immediately to the Administrator for follow up
- Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.

Date of Completion July 26 2016

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F329

I. Following elements were implemented to correct the deficiency as it relates to the individual resident #1.

- Medication incident report was completed on July 25, 2016.
- Resident 1 medications were reconciled to assure proper administration of all medication individual staff members received work performance notice and were re-educated. Re-education included medication administration as well as immediate reporting of medication error timely.

II. All residents who have had an unplanned discharge to the hospital within the last 30 days were reviewed by DON or designee. Ad medication reconciliation was completed.
- All interviewable residents who had been discharged to the hospital were interviewed by DON or designee for any concerns about medication administration. No others were identified. The DON or designee have fro the non-interviewable residents, completion of medication reconciliation for accuracy and compliance.

III. The following measures will be put in place and/or systemic changes will be made to ensure the current practice does not reoccur.
- All nursing staff have been re-educated on medication administration procedures including immediate report of medication error.
- Nursing staff were education on facility medication error policy and procedure.
- All nurses and CMA will be audited for medication administration, competency.
- Competency review will be completed upon hire then once a month x 3 months, and yearly there after.
- Staff involved in any medication errors will be re-educated and followed by report competency audit.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Director of Nursing have developed an audit tool to monitor facilities compliance with plan of correction.
- The Director of Nursing or designee will be responsible for the audit completion.
- Any negative finding will be reported immediately to the Administrator for follow up
- Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.

Date of completion July 26, 2016

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F329

I. Following elements were implemented to correct the deficiency as it relates to the individual resident 8.

- Resident #8 a psychiatric reassement was completed to review continued use of PRN Ativan and current psycophormacological intervention.
- Non-pharmacological interventions have been identified on resident care plan as well as certified nursing assistant care cardex.

II. DON or designee have reviewed all resident MAR to identify all residents with PRN psychotropic.
  - All residents with PRN psychotropic were referred to psychiatric services for utilization review.

III. The following measures will be put in place and/or systemic changes will be made to ensure the current practice does not reoccur.
  - All resident with PRN psychotropic will have a behavior mentoring record that will identify target behavior as well as non-pharmacological interventions.
  - Behavior monitoring record will be maintained with MAR.
  - List residents will PRN psychotropic will be maintained at each nurse's station.
  - PRN Psychotropic may only be administered by licensed nurse after non-pharmacological interventions have been attempted.
  - Nursing staff have all been educated on revised policy and procedures.

IV. The following will be completed and monitored to the quality assurance program.

  - The Administrator and Director of Nursing have developed an audit tool to monitor facilities compliance with plan of correction.
  - The Director of Nursing or designee will be responsible for the audit completion.
  - Any negative finding will be reported immediately to the Administrator for follow up.
  - Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.

Date of completion July 26, 2016.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F334

1. Following corrected action will be accomplished for those residents found to have ineffective by current practice.

- Resident #1 received his/her pneumonia vaccine on 7/8/13, resident #6 consent was received from family for shingles vaccine on 7/22/16, pneumonia vaccine administered on 8/2/16, resident #7 received his/her TB skin test on 7/25/16 received pneumonia vaccine on 7/22/16.

II. Other residents with the potential to be affected by the current practice will be identified and the following corrective actions will be taken.

- DON or designee have audited all resident immunization records and any immunization orders for completion/administration. Any orders that were not administered were verified with doctor and administered as ordered.

III. The following measures will be put in place and/or systemic changes will be made to ensure the current practice does not reoccur.

- DON or designee will monitor all new admission for compliance with facility policy for TB skin text and pneumonia administration.
- All orders for any immunization will be forwarded to MDS Coordinator for follow up.
- All nursing staff will be educated on facility immunization policy and procedure.
- All immunization will be recorded with electronic medical records.
- The MDS coordinator review computer generated report for missing immunization weekly.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Director of Nursing have developed an audit tool to monitor facilities compliance with plan of correction.
- The Director of Nursing or designee will be responsible for the audit completion.
- Any negative finding will be reported immediately to the Administrator for follow up.
- Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

P353

I. Following corrections were implemented to correct the deficiency.

- Director of Nursing reviewed nursing staffing for the facility to assure adequate staffing.
- Facility has hired 5 new nursing employees since 6/15/16.
- All nursing staff educated on call bell response & safety.

II. Other residents with the potential to be affected by the current practice will be identified and the following corrective actions will be taken.

- Director of Nursing or designee has reviewed all staffing for remaining scheduled to assure appropriate staffing.
- Director of Nursing has designated certified nursing assistants hall assignments for continuity of care.

III. The following measures will be put in place and/or systemic changes will be made to ensure the current practice does not reoccur.

- The Director of Nursing or designee will review daily nursing staffing with administrator daily to assure adequate staffing.
- Designated weekend supervisor will notify DON/Administrator regarding staffing.
- DON/Administrator will monitor random call bell response daily.
- All staff shall be educated on facility policy of "no call bell left behind."
- Facility has recently completed a mass mailing to all certified nursing aide and nursing in state of Iowa, along with billboard advertisement, on line recruitment.
- DON and MDS Coordinator will as needed, assume floor assignments as needed.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Director of Nursing have developed an audit tool to monitor facilities compliance with plan of correction.
- The Director of Nursing or designee will be responsible for the audit completion.
- Any negative finding will be reported immediately to the Administrator for follow up.
- Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F356

I. Following corrections were implemented to correct the deficiency.

- Daily-posted nurse staffing information has been relocated to bulletin board across from nurse station one for viewing by residents and visitors.
- Daily staffing information is reflective of daily nurse hours.
-

II. Other residents with the potential to be affected by the current practice will be identified and the following corrective actions will be taken.
- There are no other nursing staff posting in the facility.

III. The following measures will be put in place and/or systemic changes will be made to ensure the current practice does not reoccur.

- The Director of Nursing will prepare daily staffing information 24 hours prior and the 11-7 nurse will make any necessary changes prior to posting.
- Director of Nursing or designee will monitor accuracy of posting daily.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Director of Nursing have developed an audit tool to monitor facilities compliance with plan of correction.
- The Director of Nursing or designee will be responsible for the audit completion.
- Any negative finding will be reported immediately to the Administrator for follow up.
- Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F362

I. Following corrections were implemented to correct the deficiency.

- Additional dietary staff has been hired, trained and scheduled.
- Dietician has created an emergency menu that will be followed in order to provide meals on time. This will be completed by all dietary staff.
- All dietary staff have been re-educated on which staff are CCDI unit.
- All room trays will be delivered by nursing staff at posted meal times. Unit manager will ensure compliance.
- CCDI unit trays will be delivered by kitchen staff at posted meal times. Unit manager will ensure compliance.

II. The Dietary Manager screened all residents in the facility in order to identify other residents with the potential to be affected by current practice: Will be identified and the following corrective actions will be taken.

- All Kitchen and Nursing Staff have been re-educated on meal times.
- Additional staff has been hired, trained and scheduled.

III. Following measures will be put in place/and or systemic changes will be made to ensure current practice does not reoccur.

- The Dietary Manager or designee will monitor meal tray delivery times to assure compliance with designated schedule.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Dietary Manager have developed an audit tool to monitor compliance is permanent.
- The audit tool includes direct observation of all meal times.
- The Dietary Manager or designee will complete this audit daily for one month and give to Administrator for review.
- Then the Dietary Manager or designee will audit weekly for 6 months per QI Committees recommendations.
- Any findings will be reported to the Administrator immediately.
- All findings shall be reported to the QI Committee monthly for further recommendation and action.

Date of Completion Tuesday, July 26, 2016.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F364

I. The following corrections were implemented to correct the deficiency

- All kitchen staff were re-educated of proper food temperatures, taking food temperatures, frequency to take temperatures, and recording food temperatures.
- Dietary Manager has been hired, trained and scheduled.
- All kitchen staff re-educated on all dietary requirements by Dietary Manager, Dietician or designee.

II. All kitchen staff have been re-educated by Dietary Manager and training reviewed with the Administrator.
- Additional staff was hired, trained and scheduled.

III. Following measures will be put in place/and or systemic changes will be made to ensure current practice does not reoccur.

- The Dietary Manager/designee will monitor temperature/record keeping and kitchen staff training daily to assure compliance with temperatures and report findings to the Administrator immediately

IV The Administrator and Dietary Manager have developed an audit tool to monitor compliance are permanent. Results of the audit will be printed out weekly x 3 months to the QI team for review and recommendations, then every three months or as per recommendations of the QI committee.

Date of Completion Tuesday, July 26, 2016.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F371
The following corrections were implemented to correct the deficiency

1. Staff was re-educated on food temperature taking
2. Staff was re-educated on proper hand hygiene
3. Staff was re-educated on proper food handling
4. Staff was re-educated on proper gloving
5. Staff was re-educated on proper glove changes between food handling
6. Staff was re-educated on proper foot wear
7. The hand-washing sink in the kitchen was immediately repaired.
8. An Interim Dietary Manager has been hired to provide proper leadership
9. Staff was re-educated on dietary procedures.
10. Large roast beef was immediately discarded
11. Non sealed, labeled or dated items have been immediately discarded
12. All items in walk-in-refrigerator sitting on the floor have been immediately discarded
13. All items in walk-in-refrigerator without a date have been immediately discarded
14. All items in kitchen work area housed on the floor have been immediately discarded
15. All items in kitchen work area have been placed on plastic milk crates to keep them off the floor
16. All scoops have been immediately removed from flour bins
17. The facility is in the process of obtaining work estimates to professional clean the kitchen.
18. Sanitizer buckets are being used
19. Vulcan ovens have been cleaned
20. Griddle has been cleaned
21. Backsplash of stove has been cleaned
22. Shelf above steam table has been cleaned
23. Front of white cupboards in kitchen have been cleaned.
24. Milk cooler temperatures are being recorded
25. Mighty shakes in milk cooler were immediately discarded. All new mighty shakes are being dated.
26. Dry storage boxes have been placed on pallets or plastic milk crates off of floor
27. Potatoes, Crisco and unpeeled deiced red peppers, six empty cardboard boxes were immediately discarded that were housed on the floor in the dry storage area.
28. Dry storage area floor has been cleaned by housekeeping

29. Walk-in-freezer items: 30 pound box of tater tots, 6-3 pound bags of blueberries, 30 pound box of French fries, 2-3 gallon drums of vanilla ice cream, housed on the floor were immediately discarded.
30. Service hallway between dry storage and kitchen entrance has been scrubbed and waxed by housekeeping. Walls have been cleaned and painted.
31. Kitchen cleaning schedules have been posted. New notebooks have been created.
32. Walk-in-refrigerator 4-quart container half full of beets without date was immediately discarded.
33. Staff has been re-educated on facility cleaning and sanitizing policy.
34. Staff have been re-educated on proper dining room table sanitization between meal services.

II. The Administrator/designee will inspect the Kitchen daily with the Dietary Manager to assure compliance.
- All kitchen staff have been re-educated
- All kitchen staff has been re-trained on maintaining compliance.

III. Following measures will be put in place and/or systemic changes will be made to ensure current practice does not reoccur.
- Kitchen staff have been hired, trained and scheduled.
- The Dietary Manager or designee will monitor kitchen practices daily to assure compliance.

IV The Administrator and Dietary Manager have developed an audit tool to monitor compliance are permanent. The results of the audit will be print out monthly x 3 months to the QI team for review and recommendations, then every three months or as per recommendations of the QI team.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F441

I. Following corrections were implemented to correct the deficiency.

- All glucometers currently in use were disposed of and replaced with new glucometers

II. Other residents with the potential to be affected by the current practice will be identified and the following corrective actions will be taken.
- All glucometers have been replaced.

III. The following measures will be put in place and/or systemic changes will be made to ensure the current practice does not reoccur.

- All nursing staff have been re-educated on recommended cleaning direction for glucometer.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Director of Nursing have developed an audit tool to monitor facilities compliance with plan of correction.
- The Director of Nursing or designee will be responsible for the audit completion.
- Any negative finding will be reported immediately to the Administrator for follow up.
- Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F441

I. Following corrections were implemented to correct the deficiency.

- Resident 4 linen was removed from room.

II. Other residents with the potential to be affected by the current practice will be identified and the following corrective actions will be taken.
  - Director of Nursing or designee have identified non-compliant incontinent residents that reside in carpeted rooms.
  - Social worker has discussed room change with resident to non-carpeted room to aid in infection control.

III. The following measures will be put in place and/or systemic changes will be made to ensure the current practice does not reoccur.

- All nursing staff and housekeeping staff were educated on appropriate disinfecting procedure for urine and urine soaked linen when on floor.
- Housekeeping staff and nursing staff will be in serviced on room and resident identified as non-compliant.
- Housekeeping staff and nursing staff will monitor the identified room q 2 hours.

IV. The following will be completed and monitored to the quality assurance program.

  - The Administrator and Director of Nursing have developed an audit tool to monitor facilities compliance with plan of correction.
  - The Director of Nursing or designee will be responsible for the audit completion.
  - Any negative finding will be reported immediately to the Administrator for follow up.
  - Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

F467

I. Following corrections were implemented to correct the deficiency.

- Director of Maintenance has notified HVAC Company to inspect facility exhaust system.
- Resident #4 was asked to relocate to a non-carpeted room.

II. Other residents with the potential to be affected by the current practice will be identified and the following corrective actions will be taken.

- Director of Nursing or designee have identified non-compliant incontinent residents that reside in carpeted rooms.
- Social worker has discussed room change with resident to non-carpeted room to aid in infection control.

III. The following measures will be put in place and/or systemic changes will be made to ensure the current practice does not reoccur.

- All nursing staff and housekeeping staff were educated on appropriate disinfecting procedure for urine and urine soaked linen when on floor.
- Housekeeping staff and nursing staff will be in serviced on room and resident identified as non-compliant.
- Housekeeping staff and nursing staff will monitor the identified room q 2 hours.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Director of Nursing have developed an audit tool to monitor facilities compliance with plan of correction.
- The Director of Nursing or designee will be responsible for the audit completion.
- Any negative finding will be reported immediately to the Administrator for follow up.
- Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.

Plan of Correction for Pearl Valley Rehabilitation & Health Care Center, Washington, Iowa.
Accept this as the facilities credible allegations of compliance

L1093

I. Following corrected action will be accomplished for those residents found to have ineffective by current practice.

- Residents #15, #19, #20 information was submitted to the Iowa Dept. of Veteran eligibility for determination.

II. Other residents with the potential to be affected by the current practice will be identified and the following corrective actions will be taken.

- Administrator or designee has audited all current residents admissions documentation folder for any missing VA Eligibility clearance.

III. The following measures will be put in place and/or systemic changes will be made to ensure the current practice does not reoccur.

- The Administrator or designee will submit request for review of Benefits from VA eligibility. Administrative Assistant shall maintain a log of identified residents DOB, Room Date of initial request to VA date and result of benefit screening.
- Administrator shall review log weekly for compliance.

IV. The following will be completed and monitored to the quality assurance program.

- The Administrator and Administrative Assistant have developed an audit tool to monitor facilities compliance with plan of correction.
- The Administrative Assistant or designee will be responsible for the audit completion.
- Any negative finding will be reported immediately to the Administrator for follow up.
- Results of the audit will be presented to the QI Committee weekly for follow up recommendation for one month.