	of Deficiencies F Correction	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		CONSTRUCTION	(X3) DATE SU COMPLET
		165453	B. WING		0.000
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	06/23
PEÀRL VI	ALLEY REHABILITATION	& HEALTHGARE CENTER O		01 E POLK ST VASHINGTON, IA 52353	
(X4) 10 PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE 🤇
F 000	INITIAL COMMENTS		F 000		
	Correction date	-17-16		please see	8
	annual health survey Complaints #60107-C #59759-C, #59762-C #60894-C, #60449-C	5, #59808-C, #59815-C, #60893-C #60440-C and #60741-C,		Please see Attached Unis, facilities Credible Anego of compliance	tions
		l completed from Regulations (42CFR) Part		of compliance	-
	483, Subpart B-C) 483.10(b)(11) NOTIF (INJURY/DECLINE/R		F 157		Ż
	consult with the residu known, notify the residu accident involving the injury and has the pot intervention; a signific physical, mental, or p deterioration in health status in either life thr clinical complications) significantly (i.e., a ne existing form of treatm consequences, or to c	dent's legal representative y member when there is an resident which results in ential for requiring physician and change in the resident's aychosocial status (i.e., a , mental, or psychosocial eatening conditions or ; a need to alter treatment ed to discontinue an ment due to adverse commence a new form of on to transfer or discharge		Please see autached	- 6
	and, if known, the resi	promptly notify the resident dent's legal representative			
	A T	UPPLER REPRESENTATIVE'S SIGNATUR	A 1	ninistrator	(×6)1 Ø→

FORM CM9-2567(02-99) Previous Versions Obsolete

Aug.	5.	2016	2:36PM	A11	American	Care
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	No.	2040	P.	3
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PRINTED:	08/05/2016
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	MENT OF HEALTH AN S FOR MEDICARE &	MEDICAID SERVICES		· · · · · · · · · · · · · · · · · · ·	FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mult(Ple o A. Building		(X3) DATE SURVEY COMPLETED
		165453	8. WINQ	······································	06/23/2016
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O	601	LEY ADDRESS, CITY, STATE, ZIP CODE E POLK ST SHINGTON, IA 52353	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATÉMENT ÓF DEFIČIENČIEŠ Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	iD PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 157	change in room or roo specified in §483.15(resident rights under regulations as specific this section. The facility must reco the address and phor legal representative of This REQUIREMENT by: Based on record revi failed to notify the fam for 1 of 27 current res #10). The facility reportesidents. Findings include: 1. The Minimum Data tool, dated 5/27/16, list #10 to include non-Ab disorder, depression, mellitus. According to required extensive as for dressing, personal supervision and set up eating and toilet use. According to the Inctid Resident #10, dated 6	ember when there is a commate assignment as e)(2); or a change in Federal or State law or ed in paragraph (b)(1) of rd and periodically update the number of the resident's r interested family member. Is not met as evidenced ew and interview, the facility nily of a change in condition idents reviewed (Resident	F 157	Please Ser attach	8-17-1 ad

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID:0JLG11

Facility ID: 1A0948

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If continuation sheet Page 2 of 98

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No. 2040 P. 4

		ID HUMAN SERVICES MEDICAID SERVICES				FOI	ED: 08/05/2016 RM APPROVED VO. 0938-0391
STATEMENT	of deficiencies F correction	(X1) PROVIDER/8UPPLIER/CLIA IDENT(FICATION NU/MBER;	• •	PLE CONSTRUCT B		(X3) DA	TE SURVEY MPLETED
		165453	B. WING			0	6/23/2016
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		STREET ADDRI 601 E POLK S WASHINGTO			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO ACH CORRECTIVE ACTION DSS-REFERENCED TO THE DEFICIENCY	SHOULD BE	(XG) COMPLETION DATE
F 157	Resident #10 had a re the forehead. The no asked the resident ho and the resident ho and the resident did m Review of Progress N 5:30 p.m. (when the fi facility regarding the r revealed no mention of unclear speech and b measurements were f regarding the resident than the 0.5 cm x 0.5 A Progress Note for F at 6:39 p.m., stated th facility regarding the r the right side of the fo down to the ear. The was also concerned b garbled speech and w The note stated the re emergency departmen 6/12/16 at 8:55 p.m., r arrived in the Emergen over the right eye, ear During an interview or CC, Certified Nurse Ai worked the night shift Resident #10 was lear very stiff. She stated i outborsts and had take put it up to his/her face speech was garbled a	d 6/9/16 at 8:49 a.m., stated ad area on the right side of tes documented the nurse w he/she received the area of answer the nurse. dotes from 6/9/16-6/12/16 at amily inquired with the esident's condition) of the resident having eing unsteady. No further in the resident's record its forehead bruising, other cm measurement. Resident #10, dated 6/12/16 e family had spoken to the esident having a bruise to rehead that had also moved note stated that the family ecause the resident had vas unsteady on his/her feet. sident was sent to the	F 1		Nease Se attache	e 2d	8/17/16

FORM CMS-2567(02-99) Previous Versions Obsoleta

Event ID: 0JLG11

Facility (D: 1A0948

If continuation sheet Page 3 of 98

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No. 2040 P. 5

DEPART		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 08/05/2016 RM APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	· ·		DNSTRUCTION	(X3) DA	TE SURVEY MPLETED
		165453	B. WING			a	6/23/2016
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		601	EET ADDRESS, CITY, STATE, ZIP CODE E POLK ST SHINGTON, JA 52353		
(X4) (D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIN (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	0 6e	(XS) COMPLETION DATE
F 157	end of her shift, she t bed yelling. She wen resident had a "goose quarter on his/her for Licensed Practical Nu CNA/Certified Medica down to assess the r thought Staff G and S resident's speech was she then worked the i stated the resident's and he/she hardly ha stated this was strang stated she worked the and that the resident's During an Interview o G, LPN, stated she w 6/9/16. She stated in the forehead but that happened. She state abnormal speech. Sl again on the day shift resident had no abno She stated that the re came in that day and bruising. Staff G state room and he/she had had a "little raised are was "dime sized". Sh the physician and call resident. During a Interview on H, Registered Nurse i worked the night shift notice any speech pro-	tin the resident in his/her it in the room and the e egg" about he size of a ehead. She stated Staff G, urse (LPN) and Staff A, tion Assistant (CMA) came esident. She stated she esident. She stated she esident. She stated she staff A knew that the s garbled. Staff CC stated hight shift on 6/10/16 and speech was more garbled d any clear speech. She ge for the resident. She e night shift again on 6/11/16 s speech was still garbled. In 6/22/16 at 6:49 a.m., Staff orked the day shift on e resident had a red area on she didn't know what d the resident had no atf G stated she worked of 6/12/16 and that the rmal speech on this shift. sident's family members inquired about the resident's bruising on his/her ear and a" on his forehead which the stated she consulted with ed an ambulance for the 6/21/16 at 6:04 p.m., Staff	F	157	Please See attached		8-17-16

FORM CMS-2567(02-89) Previous Versions Obsoleta

Facility ID: 1A0948

If continuation sheet Page 4 of 98

		ID HUMAN SERVIÇES MEDICAID SERVICES	•	· · · · · · · · · · · · · · · · · · ·	PRINTED: 08/05/201 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ionstruction	(X3) DATE SURVEY COMPLETED
		165453	B. WING		06/23/2016
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O	601	REET ADDRESS, CITY, STATE, ZIP CODE E POLK ST ISHINGTON, IA 52353	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUSY BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE COMPLETION
F 157	shift on 6/11/16 and a speech as "a lille off	l stated she worked the night lescribed the resident's but normal" for the resident.	F 157		8-17-14
	Resident #10's family he/she went to visit ti 4:00 p.m., the resident right side of his/her for resident's speech was completely unlike the	in 6/20/16 at 2:30 p.m., in member stated when ne resident on 6/12/16 at in thad a "huge brulse" on the prehead and stated the is unclear and this was in resident. She stated no it called her regarding the par speech.		please sel	
	staff should promptly	revised April 2014, stated notify the resident's nges in the resident's	3	attained	
F 167	Resident #10's spous to the resident on 6/9 was fine. 493.10(g)(1) RIGHT	n 6/20/16 at 2:30 p.m., se stated he/she had spoken /16 and that his/her speech TO SURVEY RESULTS -	F 167	:	
SS=F∶	the most recent aurve Federal or State surv	ILE In to examine the results of ay of the facility conducted by eyors and any plan of th respect to the facility.			
	examination and mus	e the results available for at post in a place readily and must post a notice of			

FORM CMS-2567(02-99) Previous Versions Obsolete

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RINTED:	08/05/2016
FORM.	APPROVED

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED
STATEMENT	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENT(FICATION NUMBER:	(X2) MUI A. BUILC		E CONSTRUCTION	(X3) DATE COMP	SURVEY Leted
		165453	8. WING)	·	06/	23/2016
]	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		6	STREET ADDRESS, CITY, STATE, ZIP CODE S01 E POLK ST WASHINGTON, JA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) Completion Date
F 167	This REQUIREMENT by: Based on observation interviews, the facility of the most recent low inspections and Appe correction and make	is not met as evidenced n, record review and staff falled to provide the results wa Department of eals (DIA) survey and plan of the results readily nation. The facility reported	F	· 167	Please see attache	vol	8-17-16
	facility's survey result hanger near the front of an annual survey of annual inspection by dated 6/23/14. The results of the las 8/13/15 was not avail Observations through conducted 6/20/16 th any additional inform results book.	nout the annual survey rough 6/23/16 did not reveal ation available in the survey			• •		
F 208 \$S≂D	Administrator was no Information was not a book and inquired ho information. 483.12(d)(1)-(4) PRC ADMISSION POLICI The facility most not	available in the survey results w to obtain the required DHIBITING CERTAIN	F	- 208	Please see attached		8-17-14

FORM CMS-2567(02-99) Previous Versions Obsolete

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Event ID:0/LG11

Facility ID: 1A0948

If continuation sheet Page 6 of 98

(D PLAN O	op deficiencies 7 Correction	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING			e Survey Ploted
		165463	B. WING			/23/2016
	ROMOER OR SUPPLIER	N & HEALTHCARE CENTER O	601	REET ADDRESS, CITY, STATE, ZIP CODE I E POLK ST ASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefix TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULO 8E	(X5) COMPLETION DATE
F 208	Medicaid; and not re assurance that resid are not eligible for, c or Medicaid benefits The facility must not guarantee of payme of admission or expe- continued stay in the may require an indiv a resident's income for facility care to sig incurring personal fill facility payment from resources. In the case of a person nursing facility must receive, in addition to required to be paid to money, donation, or precondition of adm or continued stay in However, a nursing who is eligible for M the resident has req are not specified in the term "nursing fa	aquire oral or written lents or potential residents or will not apply for, Medicare a. t require a third party int to the facility as a condition edited admission, or e facility. However, the facility vidual who has legal access to or resources available to pay gn a contract, without nancial liability, to provide in the resident's income or son eligible for Medicaid, a that charge, solicit, accept, or to any amount otherwise under the State plan, any gift, other consideration as a ission, expedited admission	F 208	Please Jer atta	Cred	8-17-1
	precondition of adm or continued stay in However, a nursing who is eligible for M the resident has req are not specified in the term "nursing fa	ission, expedited admission the facility. facility may charge a resident iedicald for items and services juested and received, and that the State plan as included in cility services" so long as the				

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Aug	. 5. 2016 2:37	PM All American Care			No. 2040	P. 9
DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 06/05/2016 FORM APPROVED OMB NO: 0938-0391
STATEMENT	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		165453	B. WING			06/23/2016
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STAT	TE, ZIP CODE	1 00/23/2010
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O	ł	101 E POLK ST NASHINGTON, IA 52353		
(X4) ID PREFIX TAQ	(EACH DEFIGIENG	ATEMENT OF DEFICIENCIES Y MUST BE PRECÉCIO BY FULL LSC IDENTIFYING INFORMATION)	id PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION IVE ACTION SHOULD B CED TO THE APPROPRI FICIENCY)	
F 208	extent that the contrib admission, expedited stay in the facility for States or political sub admissions standards than are specified in it discrimination agains Medicaid. This REQUIREMENT by: Based on record revi facility failed to follow Policy for 1 of 27 curr (Resident #1). The fai 60 residents. Findings include: Review of Resident # resident was admitted Review of Resident's indication an agreeme signed by the residen During an interview of	Autilon is not a condition of admission, or continued a Medicald eligible resident. divisions may apply stricter s under State or local laws his section, to prohibit t individuals entitled to ' is not met as evidenced ews and interviews, the their Admission Agreement ent residents reviewed cillity reported a census of 1's face sheet revealed the i to the facility on 4/7/16. #1's records lacked and contract completed and	F 206	Please See a	ttaehed	7.17-1 6
	paper explained and (signature was a code (CPR/DNR Status). R never received or sign					
ORM CMS-256	Residents Bill of Right In an interview on 5/2 Registered Nurse, sta locate an admission o	ts. 5/16 at 11:40 a.m., Staff FF, ted they were unable to ontract for Resident #1 and the facility ever completed 5/16 at 3:22 p.m., the		- Яцу IQ: ТА0948	If continu	ution sheet Pege 8 of 98

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Aug. 5. 2016 2:37PM All American Care

No. 2040 P. 10

		MEDICAID SERVICES	······································		1	<u>O. 0938-039</u>
	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPL)ER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	e construction		e Survey IPleted
		165453	B. WING	2	00	/23/2016
NAME OF P	ROVIDER OR SUPPLIER		<u>ا</u>	SYREET ADDRESS, CITY, STATE, ZIP CODE	t	
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O		301 E POLK ST NASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFIC)ENC	atemeny of deficiencies Y Must be preceded by full LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	SULD BE	(X5) COMPLETION DATE
	D . Hunsel Fac					8.17.1
F 208 F 225 \$\$=D	Administrator stated i admission packet loc Administrator stated i and Administrator are the admission agreen admissions. The Adm all residents are to ha completed. The 12/2006 Admissi Statement, Policy Inte Implementation, Inclu admission, the reside must sign an Admissi- that outlines the servi per diem rate, as well requested by the resid- the basic per diem rat Agreement will be pro- his/her representative be placed in the resid 483.13(c)(1)(ii)-(iii), (c) INVESTIGATE/REPO ALLEGATIONS/INDIV The facility must not e been found guilty of a mistreating residents i had a finding entered registry concerning at of residents or misapp and report any knowle court of law against an indicate unfilness for so other facility staff to tho or licensing authorities	no admission agreement or ated for Resident #1. The both the Director of Nursing responsible to make sure nent is completed on new aninistrator further indicated two an admission agreement on Agreement Policy arpretation and ded at the time of nt (or his/her representative) on Agreement (contract) ces covered by the basic is as any additional services dent that are not covered by the A copy of the Admission ovided to the resident or e (sponsor), and a copy will ent's file. e)(2) - (4) RT /IDUALS employ individuals who have busing, neglecting, or by a court of law; or have into the State nurse aide puse, neglect, mistreatment propriation of their property; edge It has of actions by a in employee, which would service as a nurse aide or ne State nurse aide registry s.	F 208	Please see atta	xched	

FORM CMS-2567(02-99) Previous Versions Obsolete

Fedility ID: 1A0948

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED;	08/05/2016
FORM	\PPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>), 0938-0391 </u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLVA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		SURVEY PLETED
		185453	B. WING			06	23/2016
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		e	STREET ADDRESS, CITY, STATE, ZIP CODE 501 E POLK ST WASHINGTON, 14 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) Completion Date
F 225	including injuries of un misappropriation of re- immediately to the ad- to other officials in ac- through established p State survey and cert The facility must have violations are thoroug prevent further potent investigation is in pro- The results of all inve- to the administrator or representative and to with State law (includi certification agency) v incident, and if the allo	nknown source and isident property are reported ministrator of the facility and cordance with State law rocedures (Including to the ffication agency), evidence that all alleged hly investigated, and must tal abuse while the gress.	F	225	Please See attack	Yed	8-17-16
	by: Based on record revi failed to report an alle residents involved in a altercation (Resident a reported a census of (Findings include: 1. The Minimum Data tool, dated 5/9/16, list #8 of non-Alzheimer's stated the resident red staff for bed mobility, i eating, tollet use, pers	W8 and #21). The facility 50 residents. a Set (MDS) assessment ed a diagnosis for Resident					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0JLG11

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Facility JD: 1A0948

If continuation sheet Page 10 of 98

		D HUMAN SERVICES MEDICAID SERVICES			FOR OMB N	D: 08/05/201 MAPPROVE 0, 0938-039
	F DEFICIENCIÉS CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		165453	B. WING		- 06	/23/2016
NAME OF PR	IOVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 E POLK ST		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		WASHINGTON, IA 52353		
(X4) (Ö PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	* PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	DULD BE	(X5) COMPLETIO DATE
F 225	the resident had trout and was short-tempe. MDS review period had physical behavior toward others daily at symptoms directed to week. The MDS liste severely Impaired. Review of progress n 5/10/16 at 9:22 a.m., hitting and punching of Review of Progress N 6/18/16 at 6:29 p.m., aggressive and agitat residents. The facility lacked an occurrences and lack occurrences being rej Inspections and Appe The care plan for Res directed staff to call th visit or talk on the pho he/she "won't settie". to: intervene before a resident away from th engage calmly in com resident's response w calmly and approach 2. The MDS assess n listed a diagnosis for	and inattention and stated ble concentrating on things red nearly every day of the Fhe MDS stated the resident ral symptoms directed and had verbal behavioral ward others 4-6 days of the d the resident's cognition as bles for Resident #8, dated revealed the resident was other residents. Notes for Resident #8, dated revealed the resident was other residents. Notes for Resident #8, dated revealed the resident was other residents. Notes for Resident #8, dated revealed the resident was ed and was hitting other incident report for the above ed documentation of the ported to the Department of als. Notes the resident when The care plan directed staff gitation escalated, guide the e source of distress, versation, and, if the as aggressive, walk away later. Nent tool, dated 5/16/16, Resident #21 of entia. The MDS stated the	F 22	5 Please Lee attal	thed	8-17-1

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA1	O. 0938-039
NU PLAN UI	· CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING	ä	000	IPLETED
		165453	B. WING			5/23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
PEARL V	LLEY REHABILITATIO	N & HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX Tag	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) Completion Date
F 225	BIMS (Brief Interview of 15, indicating interview of 15, indicating interview Review of an Incider Resident #8, dated 5 #21 walked over to F him/her down. The to the right side corner was not bleeding and no signs of pain. The would attempt to kee much as possible. The facility lacked do occurrence being reg Inspections and Appe The facility Resident Practices - Abuse po 2009, directed all sus resident to resident a the State licensing/of hours. During an interview of Staff FF, Registered stated anytime a resident a	v for Mental Status) score 14 ct cognition. M/AccIdent Report for i/20/16, revealed Resident Resident #8 and pushed report stated Resident #8 hit of his/her mouth but that it d the Resident #8 indicated e report stated the facility up the residents separated as ocumentation of the ported to the Department of eals. Behavior and Facility licy, revised December spected violations, including ibuse should be reported to ertification agency within 24 on 6/22/16 at 4:53 p.m., the Nurse/MDS Coordinator dent to resident altercation a reported to the Department	F 22	5 Please See att	ached	8-17-14
	Director of Nursing st resident altercation o separate the resident Nursing, and call the hours. She stated sh	n 6/22/16 at 4:53 p.m., the tated when a resident to ecurred, staff should is, notify the Director of State agency within 24 te needed to do some agarding the reporting of				

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Aug. 5. 2016 2:39PM All American Care

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No. 2041 P. 4/27

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/05/2018 MAPPROVED D: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAYE Comf	SURVEY PLETED
		165453	B. WING			06/	23/2016
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		6	STREET ADDRESS, CITY, STATE, ZIP CODE 501 E POLK ST VASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION}	id Pref Tac		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCEO TO THE APPROPRIA DEFICIENCY)		(X5) Completion Date
F 246 F 246 S5=E	OF NEEDS/PREFER A resident has the rig services in the facility accommodations of in preferences, except v the individual or other endangered. This REQUIREMENT by: Based on observation interviews, the facility return from the dining assist residents that r (Resident's #6 and #7) residents attendance appointments (Reside Twenty-seven curren The facility reported a Findings include: 1. The Minimum Data dated 5/6/16 revealed that included non-Alz severe cognitive loss required extensive as members for transfer bathing, toileling, drev and supervision with	NABLE ACCOMMODATION ENCES In to reside and receive with reasonable individual needs and when the health or safety of residents would be T is not met as evidenced in, record review and staff railed to assist residents proom after meals, failed to required meal assistance 7), and failed to assist at scheduled medical ant's #1, #2 and #12). t residents were reviewed, a census of 60 residents.	1	246 246	1	ed	8-17-16 8-17-16
					<u> </u>		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; DJLG11

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Facility ID: 1A0948

If continuation sheet Page 13 of 98

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	g. 5. 2016 2:39 TMENT OF HEALTH AN)PM All American Care ND HUMAN SERVICES	e		No. 2041	PRINTE	-5/2/ ED:-66/05/2016 RM APPROVED
		MEDICAID SERVICES		_			MAPPROVEL 10. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	TE SURVEY APLETED
		165453	B, WING	·		<u> </u>	6/23/2016
NAME OF F	PROVIDER OR SUPPLIER			f	STREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL V	ALLEY REHABILITATION	N & HEALTHCARE CENTER O	: 		601 E POLK ST WASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	id Prefi Tag	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X8) COMPLETION DATE
	1						8-17-16
F 246			F	- 246	ô		¥ · -
ł	January, 2016 168.2		-				
	February, 2016 162						
	March, 2016 159.8 j April, 2016 155.0 pc						
i L	May, 2016 155.0 pc						
	June, 2016 153,0 pounds						
	Desident #Gla provin	······································					
		g care plan included a 3 Activities of Daily Living					
	(ADL) self-care perfor	ormance deficit, with 8/10/16					
	goal the resident wou	uld maintain current level of			DIDALD		
ļ		id interventions that included:			1 Fuerose	-	
		ds when the resident has				~	
	difficulty using utensil 2. The resident regula	us. Ires supervision/limited			please see attach	\mathcal{D}	
	assistance by 1 staff						
ĺ		e plan problem identified as					
l		id a 6/10/16 goal that the					
l		fewer episodes of yelling and interventions that included:					
l		Interventions that included: ty for positive interaction,					
l		alk with the resident when	ł	1			1
	passing by.			1			
		ssary to protect the rights		1		5	
l	and safely of others. take to alternate locat	Remove from situation and stion as peeded		1			
	3. Monitor behavior e			1	-		
	determine underlying			1			
		tole transcribed by the		;			
l	facility's consultant Di	Dietician stated: resident		1			
ł		ning room which is more		,			
ł		aten better in last 3 weeks in day weight loss of 7.8		,			
l		began when resident moved		,			
ľ		ing room to the main dining		,			
1	room. Recommended	ed resident to continue eating		'			
<i>i</i>	In the assisted dining	room and laboratory work				:	

FORM CMS-2567(02-39) Previous Versions Obsolete

Event (D:0JLG11

Facility ID: 1A0949

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If continuation sheet Page 14 of 98

Aug. 5. 2016 2:39PM All American Ca	Aug.	5.	2016 -	2:39PM	A11	American	Care
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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No. 2041 P. 6/27

PRINTED:	08/05/2016
FORM	APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB	NO. 0938-0391
	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:			NSTRUCTION		ate survey DMPLETED
		165453	Đ. WING				06/23/2016
NAME OF PI	RÓVIDER ÓR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
			<i></i>	601 E	POLKST		
PEARL VA		& HEALTHCARE CENTER O		WAS	HINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUSY BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X6) Completion Date
F 246	that included a compl	ele medical profile and	F	246	- - -		8-17-14
	via facsimile (fax). Th	te was sent to the physician a physician confirmed the and returned the document					
	Observations of the r	esident revealed:					
	6/21/16 at 7:55 a.m., room, wilhout food or	seated in the main dining beverages.			Please		
	room, silverware wran in front of the residen	seated in the main dining oped in a napkin, breakfast t that included a bowl of hot of bacon and scrambled			Please See attack	red	
	main dining room tabl eyes closed, silverwa	remained seated at the le, slumped forward with re remained wrapped in a a any food presented and no		:			
	Continuous observati 6/21/16 between 8:52 revealed the resident in the chair at the tabl napkin, no assistance dishes removed from						
	resident remained in t without any intervention when the nurse praction	(he dining room chair, on by staff, until 10:14 a.m. Iloner asked Staff S, CNA), to assist her to take					
	resident seated in the				 D: 140948 If cc		1990t Page 15 of 98

		AND HUMAN SERVICES		:	. –	RM APPROVE NO. 0938-039
STATEMENT	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DA	YE SURVEY MPLETED
		165453	8. WING)6/23/2016
NAME OF P	ROVIDER OR SUPPLIER		STF	REET ADORESS, CITY, STATE, ZIP CODI		
PEARL VA	LLEY REHABILITAT	ON & HEALTHCARE CENTER O		E POLK 8T SHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFIGI	(Statement of Deficiencies Ency must be preceded by full or LSC identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) Completion Date
F 246	1	lstance for the resident, CNAs	F 246			8.17.16
	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.					
	resident remained without assistance	24/16 at 8:52 a.m. revealed the seated in the dining room a, silverware wrapped in a nt had not eaten as the distary ubles.		Please atto		
	a.m., the Director resident yelled wh	cht tour on 6/20/16 at 10:05 of Nursing (DON) stated the en in crowds and staff required deni to a quiet area to reduce aviors.	-	See atta	rehed	
	Diotician stated fx to eat, tables on it room were design meal assistance w was closed and st feeding assistance	w on 6/22/16 at 2:50 p.m., the asident #6 required assistance be west side of the main dining ated for residents that required when the assisted dining room aff should continue to provide as needed to the resident at main dining room if the assisted losed.		-		
	2. Observation on 6/21/16 in the main dining room revealed:					
	7:55 a.m Reside approximately 30 breakfast meal.	nt #6 seated with other seated residents for the		:		
		nt #6 and Resident #7 seated				

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Aug. 5. 2016 2:40PM All American Care

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM A OMB NO. 0	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		E CONSTRUCTION	(X3) DATE SU COMPLET	
		165453	B. WING		06/23/	2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		BOIEPOLKST WASHINGTON, IA 52353		
0/11/0	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS REFERENCED TO THE APP DEFICIENCY)		(X6) COMPLETI DATE
F 246			F 246		.ک	3-17.
F 240			F 240	1		
	meal.) residents for the breakfast				
	8:43 a.m Resident					
	remained in the dinin 35 residents for the b	g room with approximately reakfast meal.				
	A conlinuous observa 6/21/16 between B:52 revealed:	tlion in the dining room on 2 a.m. and 11:09 a.m.				
		d seated in a regular chair				
		the nurse practitioner		VIDAL		
		for assistance to transfer the		Fiend		
	resident to his/her roo	om for assessment.		please su attal	had	
	Poeidont #7 romaine	d seated in his/her wheel		pa cont		
		10:11 a.m. when the				
		assistant and physical				
	therapist assisted the	resident to stand, then				
	ambulated the reside	nt out of the dining room.				
		ied on the west side of the				
	dining room and pres					
	observation remained Staff S, CNA, assiste	at the same location until				
		n from the dining room at				
	9:47 a.m.	Thom are easing toon; at				
		ied in a wheel chair on the				
		ig room at the 7:55 a.m.				
		at the same location until			1	
		ff M, GNA, assisted the dining room at 9:53 a.m.				
	Activities were not off	ered in the dining room				
	throughout the observ					
	Staff M, CNA, assign	ed to the 100 and 200 halls,				
RM CMS-256	7(02-99) Previous Versions Obs	olele Event 10:03L0	911 Fe	cellity (D: 1A0948 IF	continuation sheet Pa	ae 17

Aug.	5.	2016	2:40PM	A11	American	Care

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No. 2041 P. 9/27

		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 09/05/201 DRM APPROVE(NO: 0938-039
STATEMENT	of deficienciés F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		DNSTRUCTION	(XS) D/	ATE SURVEY MPLEYED
		165453	B. WING				06/23/2016
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		601	EET ADDRESS, CITY, STATE, ZIP CODE E POLK ST SHINGTON, IA 52353		
(X4) (D 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(%) Completion Date
F 246	Staff N, CNA assigned and Staff DD, CNA a 600 halls were the or 6:00 a.m. to 2:00 p.m 6/21/16. Staff W, Certified Me was assigned as a C 200 halls), and Staff CNA when observed 6:00 a.m. and 6:45 a CMA for Station 2 (30 7:00 a.m. Staff S, CNA schedu p.m. to 10:00 p.m.) W room at 9:47 a.m. The Director of Nursi called in early to wor p.m. The only other at that time (other the coordinator nurse) W	e 17 ed to the Memory Care unit, assigned to the 300, 500 and nly CNAs scheduled for the n. shift and on duty on edication Aide (CMA)/CNA, SMA at Station 1 (100 and R, CMA/CNA functioned as a on the 100 hall between h.m., then assigned as the 00, 500 and 600 halls) after led for the evening shift (2:00 vas observed in the dining ing (DON) stated Staff S was k and would stay until 10:00 nursing staff in the building an the DON and MDS vas Staff G, LPN, who rse on duty for all facility	F 2		Please See attach	ad	8.17-11
	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.		1 - - -	5			
	MDS revealed the re	/14/16 for Resident#1 dent Intact memory. The sident required extensive iff members for bathing, and					

FORM CMS-2567(02-99) Previous Versions Obsolete

had bilateral lower extremity weakness. The MDS

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Facility ID: 1A0948

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If continuation sheet Page 18 of 98

Aug.	5.	2016	2:40PM	All American Care
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No. 2041 P. 10/27

Aug	5. 2016 2:40	PM All American Care			No. 2041	۲.	10/27
DEDADT		ID HUMAN SERVICES					D: 08/05/2016
		MEDICAID SERVICES					MAPPROVED 0.0938-0391
STATEMENT	of Deficiencies F Correction	(X1) PROVIDER/SUPPLIER/CL)A IDENTIFICATION NUMBER:			5 CONSTRUCTION	(X3) DAT	e Survey Pleted
		165453	B. WING			08/23/2016	
NAME OF P	ROVIDER OR SUPPLIER		<u>_</u>	ទាំ	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	120/2010
					OI E POLK ST		
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O		W	VASHINGTON, 1A 52353		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ið Prefi Tag	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) Completion Date
F 246	documented that the disease, a seizure dis During an interview o resident reported that set up two months in injection for his/her cl knew about it. The re- missed out on the ap- facility did not arrang- resident reported that reschedule for 6/29/1 been very happy. A Doctors Progress N documented the resid- symptoms of back pa- stenosis. A small incr needed Percocet 1-2 needed. The resident which he will be seein majority of the resider and medications will in A Doctors Progress N documented the resider pain with his/her spin discussed increasing one tablet every four A Medical Doctor/Nur dated 6/21/16 directe sure that the pain clim S. The MDS dated 5/4 documented the resider the MDS revealed th	resident had Parkinson's corder, and heart fallure. In 6/21/16 at 7:30 a.m. the the/she had an appointment advanced to get a botox monic pain, and the facility sident reported that he/she pointment, because the a the transportation. The the appointment had been 6, the doctors office had not lote dated 4/28/16 lent had worsening in secondary to spinal ease in the resident's as tablets every 6 hours as does have a pain specialist ing in early June. The nt's chronic pain regimen be deferred to him. lote dated 6/2/16 lent had significant back al stenosis and the doctor the resident's Percocet to hours as needed. along Communications form d the facility staff to make ic appointment is kept. 5/16 for Resident #2 lent with intact cognition. at the resident required of one person for balhing.	F	-	Please See attacha	ð	8-17-16

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID; 1A0946

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If continuation sheet Page 19 of 98

Aug. 5. 2016 2:40PM All American Care

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No. 2041 P. 11/27

		ID HUMAN SERVICES	i		<i>;</i>		PRINTED: 08/05 FORM APPR OMB NO, 0938	OVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/8UPPLIER/CLIA IDENTIFICATION NUMBER;	1		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	r
		165453	B. WING	à	<u>. </u>		06/23/2010	6
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		6	STREET ADORESS, CITY, STATE, ZIP COL SOI E POLK ST WASHINGTON, IA 52353)E	•	
(X4) ID PREPIX TÀG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IC PRE TA	FIX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	n Shoùld B Eappropri/		ÉTION
F 246	diagnoses including p and diabetes, and ch indicated the residen ulcer. A Progress Note date the resident needed a follow-up and evalual resident's history of k disease in the face of chronic ulcers to both progress note docum a referral to vascular overdue for vascular vascular surgery tear that the resident had the vascular surgery, arranged as soon as known to have extens disease along with ey (blood clot history). During an interview o clinic Registered Num resident's clinic recor resident had been se surgery. The clinic R had been seen at the have been a report in that revascularization pressure ulcers heal. During an interview o resident reported that hospital clinic for the appointment had been	beripheral vascular disease, ronic pain. The MDS t had an unhealed pressure and 6/3/16 documented that a repeat vascular surgery lion due to the severity of the nown peripheral vascular f ongoing problems with a lower extremities. The ented that the doctor placed aurgery as the resident is surgery follow-up with the n. The doctor documented previously been followed by The resident needs this possible as the resident is sive peripheral vascular densive venous thrombosis n 6/22/16 at 4:15 p.m. the se (RN) reported the d lacked documentation the en for the revascularization N reported if the resident hospital clinic, there would his/her chart. Staff reported would help the resident's n 6/23/16 at 6:45 a.m. the che/she had not been to the vascular follow up, the n canceled by the facility, cheduled. The resident was not sure if the	F	246			2d	r Ho
FORM CMS-258	7(02-99) Previous Versions Obs	olaio Évent iD:0	JLGII	Fa	cilly (D: 1A0946	lf continu	allon sheel Page 20	0 of 98

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Aug.	5. 2016 2:41	PM All American Care		No. 2041	P. 12/27
DEPART	MENT OF HEALTH A	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/05/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DP DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		165453	B. WING		06/23/2016
NAME OF P	TOVIDER OR SUPPLIER	•2.		TREET ADDRESS, CITY, STATE, ZIP CODE	•
PEARL VA	LLEY REHABILITATION	A & HEALTHCARE CENTER O		DI E FOLK ST (ASHINGTON, IA 52353	· · · · · ·
(X4) (D PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES Y MUSY BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION BHOULD CROSS-R&FERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION IATE DATE
F 246	Continued From pag	e 20	F 246	:	8-17-16
	documented the resil The MDS revealed the diagnoses including disease, and ascorbin During an Interview of resident reported that have an appointment out his/her numbnes arranged by the facil reported that his/her resident reported that had called to schedu appointment when the discovered the resided A Medical Doctor/Nu dated 3/28/16 directed	anemia, coronary artery c acid deliciency. on 6/22/16 at 9:45 a.m. the t he/she was suppose to t with a specialist to check is in the legs, that was to be ily a month ago. The resident tegs are very painful. The t his/her general practitioner le the referral after the last e general practitioner ent not seen by the specialist. rsing Communications form ad the nursing staff to make a ppointment for the resident's		Please Der attacher	
F 252 SS=D	dated 6/09/16 docum needed a neurologist increased numbness fower extremities. Th appointment had bee then to follow up with practitioner on 7/7/16 483.15(h)(1) SAFE/CLEAN/COMF ENVIRONMENT The facility must provi comfortable and hom	ORTABLE/HOMELIKE	F 252	Please See attached	8-17-16

FORM CMS-2567(02-89) Previous Varsions Obsolete

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Fadlity ID: 1A0948

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Aug.	5.	2016	2:41P	M	A11	Americ	a n	Care		No
DEPARTM CENTERS										
STATEMENT OF AND FLAN OF C						VSUPPLIER/ ATTON NUMB			(X2) MULTIPLE CONSTRUCTION A. BUILDING	

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PRINTED: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391
(VA) DATE SUBJEY

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:			IO	(X3) DATE SURVEY COMPLETED	
		165453	B. WING		06/23/2016	
	ROVIDER OR SUPPLIER	DN & HEALTHCARE CENTER O		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E POLK ST WASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIE	Statement of Deficiencies Noy Musy be preceded by Full, Dr LSC Identifying Information)	ID. PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION (CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION	
F 252	Continued From pa to the extent possi	-	F 2	52	8-17-14	
	by: Based on observa the facility falled to homelike environm	NT Is not met as evidenced tion and resident interviews, maintain a clean, comfortable, ent for 1 of 27 current (Resident #1). The facility of 60 residents.		Please sue atta	Ched	
	dated 4/14/16 iden included non-Alzhe disorder and Parkir revealed the reside for Mental Status) a resident with intact the resident require	ata Set (MDS) assessment lified Resident #1's diagnoses Imer's dementia, seizure ason's disease. The MDS ant with a BIMS (Brief Interview score of 15 of 15, Indicating the cognition. The MDS identified ad limited assist of one staff obility ambulation in room, and	х 	· ·		
	Resident #1's room to close due to ove soiled incontinent b noted in the room. In an interview on \$ #1 stated he/she ha have the trash remu one is available. Re contains his/her soi it bothers him/her.	20/16 at 10:10 a.m. revealed a trash bin with the lld not able r flow of trash that included riefs. A strong smell of urine 5/20/16 at 10:10 a.m., Resident as asked staff for 3 days to oved from the room but to no osident stated the trash iled incontinent briefs in it and				
	483.15(h)(2) HOUS MAINTENANCE SE		F 25	Please See att.	alhed 8-17-16	

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Aug. 5. 2016 2:41PM All American Care

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No. 2041 P. 14/27

RINTED: 08/05/2016
FORM APPROVED

		D HUMAN SERVICES MEDICAID <u>SERVICES</u>				FORM APPRON OMB NO. 0938-03
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		165453	B. WING			06/23/2016
	RÖVIDER OR SUPPLIER	& HEALTHCARE GENTER O		STREET ADDRESS, CIT 601 E POLK ST WASHINGTON, IA		•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefix Tag	(FACH CO	DER'S PLAN OF GORRECTION DRECTIVE ACTION SHOULD ERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET
F 253		ide housekeeping and necessary to maintain a	F 25	3		8-12-
	by: Based on observatio Interviews, the facility housekeeping and mi necessary to maintair	aintenance services a sanitary, orderly, able Interior, The facility		Plea Se	e attach	ed
		out the annual survey and ntal tour conducted on a.m. and 10:22 a.m.	e			
	in the dining room will dark-colored linear so	own colored laminate floor h numerous deep, long, ratches throughout the le from 4 to 5 feet away				
	approximately 2 inche west and north walls i heating vent in the As	ue and a heavy overed the wall surface as high, and the length of the below the wall mounted sisted Dining Room. The at least 20 feet away from		1		
	tiles in the 300 hall so measured approximat Inches wide, and the	es long by 24 Inches wide		adiiy (D; 1A0948		valion sheel Page 23 o

	ALTH AND HUMAN SERVICES XARE & MEDICAID SERVICES		FORM A OMB NO. (
TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPL(ER/CL)A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) PATE SU COMPLE
	185453	8. WING	06/23
NAME OF PROVIDER OR SUP	PLIER LITATION & HEALTHCARE CENTER O	STREET ADDRESS, CITY, STATE, ZIP CODE 601 E POLK ST WASHINGTON, IA 52353	
PREFIX (EACH I	MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL TYORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP ; DEFICIENCY)	IOULD BE
 blackish-gree appearance i less than 20 shared by an #300). 4. Walls acro covered with 36 inches. C brown colore measured ap and 6 inches linear bulged along the low appeared to i surface. The opposite side hard when to 5. A fenced of beds along the approximatel approximatel approximatel raised flower contained we time, the mal control was n residents and to care for the 	by make a line of clular shaped, dark on colored area of mold-like inside the water damaged area and inches away from the common wall occupted resident room (Room as from the Statton 2 nurses statton wall paper on the lower approximate ine area at the corner had 2 dark d stains of unknown origin that proximately 10 inches by 10 inches by 3 Inches. Another wall had a area approximately 10 feet long ter 15 inches of the wall and indicate water damage beneath the boiler room was located on the of the wall. The bulged area was uched. ourlyard area outside with flower he north and east walls, y 1/3 weed-filled, with heights of 20 The flower beds were y 36 inches wide, one was y 40 feet long and the other y 12 feet long. A triangular shaped bed in the middle of the area also eds. During an interview at that intenance supervisor stated weed acreational therapy for one of the i no staff were specifically assigned	F253 Please See atta	rchæd

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P. 16/27 No. 2041

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

DEPART	MENT OF HEALTH AN	ID HUMAN SERVIC	ES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICE	ES				OMB NC	<u>), 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIE		•••	CONSTRUCTION	_	(X3) DATE COMP	SURVEY PLETED
		165453		B. WINQ			06/	23/2016
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY,	STATE, 2IP CODE	•	•
PEARL VA	LLEY REHABILITATION	& HEALTHCARE GEN	TER Ó	-	01 E POŁK ST VASHINGTON, IA 523	353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENYIFYING INFORM	FULL	id PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPR DEFICIENCY)	BE	(XG) Completion Date
F 253		e 24 exterior wall near the naintenance supervis from a previous doo removed. Inside the Memory Cr ors had 5 holes on ea panels that monitore were removed. Fou oximately 3/4 inches over an inch in diam bervisor stated mainter refinish the wall surf it was occupied by 7 the survey. 98, 310, 311, 312, 600 007, 609 and 611 had with unsightly stains #300 had a circular s hes across. Room #6 tain located near the pately 5 feet from the other of the room a Room #607 had a sta by 21 inches in the m	Sor rbell are unit ach wall ed the ur of the across eter. enance aces. 0, 602, 1 visible tain i01 had foot of pom by 12 ind ain that	F 253				8-17-16
	10. A strong urine odd resident rooms #604, the aurvey. During au Administrator stated t moved to one side of staff resources and w and remodel projects. supervisor stated that	#606 and #611 throu n Interview at that tim hat residents would to the building to conso rould enable required . The maintenance	ughout ie, the de ildate repairs					
FORM CMS-258	7(02-99) Previous Versions Obs	olete	Event ID:0JL011	Fa	cillity ID: 1A0948	if contin	uation shee	l Page 26 of 98

	Aug.	5.	2016	2:42PM	- All	American	Care
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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No. 2041 P	17/27
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PRINTED: 08/05/2016
FORM APPROVED

C <u>ENTER</u>	S FOR MEDICARE &	MEDICAID SERVICES			÷	OMB NO	0938-0391
		(X1) PROVIDER/SUPPLIER/GLIA (DENT(FICATION NUNBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		165453	9, WING			06/3	23/2016
NAME OF PL	ROVIDER OR SUPPLIER	• • • • • • • • • • • • • • • • • • •		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL VA	ILLEY REHABIL)TATION	& HEALTHGARE CENTER O			01 E POLK ST VASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN OF CORRECTION (GACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) Completion Date
F 253	the source when reloce extractor to remove c removed in room order. The maintenance sup environmental tour the started wall paper representace the walls as walls in the facility woo	cated, and the facility has an arpet stains and would be ervisor stated during the at maintenance steff had noval in the 200 hall, would s required and then paint, all	F	253	Please see attach		z-17-16
	tool, dated 5/9/16, list #8 of non-Alzheimer's stated the resident re staff for bed mobility, eating, tollet use, per- The MDS listed the re severely impaired. During an observation Resident #8's toilet he base and the rim of the 12. The MDS dated to Resident #9 of cerebrand diabetes mellitus resident required exter for bed mobility, dress and totally depended use, and bathing. Th	n on 6/21/16 at 8:54 a.m., ad black drips covering the ne bowl. 5/12/16, listed diagnoses for rovascular accident (stroke) . The MDS indicated the onsive assistance of 2 staff sing, and personal hygiene, on 2 staff for transfers, toilet e MDS listed the resident's for Mental Status) score as					
COBU CN8-954	7(02-99) Previous Versions Obs	olalo Event ID:0.4.G1	<u> </u>	Fax	ility ID: 140948 If conti	nuation sheel	Page 28 of 98

Aug. 5. 2016 2:42PM All American Care

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No. 2041 P. 18/27

		ID HUMAN SERVICES		-		F	TED: 08/05/2016 DRM APPROVED NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		ATE SURVEY OMPLETED
		165453	B. WING				06/23/2016
	ROVIDER OR SUPPLIER	& HEALTHGARE CENTER O	.	601 E	ET ADDRESS, CITY, STATE, ZIP CODE POLK ST HINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION GROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE
F 253	Continued From page During an observation the floor in the reside and food crumbs wer the resident's bed. 13. Observations of i revealed the following a. During an observa shower room on 6/21 had orange and black Thick dust particles h The grout in between covered with a black b. During an observa room on 6/21/16 at 60 was covered with a nu The hon-slip pads on were coming up and i mat in front of the sho brown. c. During an observa- room on 6/21/16 at 70 between the shower for orange and black sub shower was covered	a 26 In on 6/21/16 at 6:34 a.m., nt's room was slicky feeling e present around and under the facility shower rooms g: titon of the the 100 Hall /16 at 6:54 a.m., the shower is ubstances on the tile. ung down from the vent. The shower tiles was substance, allon of the 500 Hall shower f58 a.m., the shower floor ust-like orange substance. the bottom of the shower missing pleces. The rubber ower was discolored a dingy		263			8-17-16
	Policy stated that the	invironmental CleanIng resident care environment would be maintained in a	-				
FÖRM CMS-258	11:49 a.m., the Admir	n 6/23/16 at approximately istrator acknowledged the y was a concern. She olste Event (0:0/LC	} }{1	Facility	1D: 1A0940	ll conlinuation a	hael Page 27 of 98

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	-	ID HUMAN SERVICES MEDICAID SERVICES		v	FORM	: 08/05/2016 APPROVED . 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	PLE CONSTRUCTION	(X3) DATE 8 COMPL	SURVEY
		165453	B. WING		06/2	3/2016
NAME OF P	ROVIDER OR SUPPLIER	••••••••••••••••••••••••••••••••••••••		STREET ADDRESS, CITY, STATE, ZIP CODE		
PEÀRL VA	ALLEY REHABILITATION	& HEALTHCARE GENTER O		601 E POLK ST WASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIÉNCIES Y MUST BE PRECEDED BY FULL .8C IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) Completion Pate
	stated she had had a housekeeping and ma indicated the problem 483.15(h)(3) CLEAN I GOOD CONDITION The facility must provi linens that are in good This REQUIREMENT by: Based on observation the facility failed to pro- for 2 of 27 current rest #1 and #3). The facility residents. Findings include: 1. The Minimum Data Identified Resident #1 non-Alzheimer's deme disease. The MDS rev BIMS (Brief Interview I 15 of 15, indicating the long term memory pro- with cognitive skills for skills. The MDS Iden(if	meeling with the aintenance staff and would be addressed. BED/BATH LINENS IN ide clean bed and bath is condition, is not met as evidenced as and resident interviews, ovide washcloths and towels idents reviewed (Resident y idenlified a consus of 60 Set (MDS) dated 4/14/16, diagnoses included entia and Parkinson's realed the resident with a for Mental Status) score of a resident with no short or blems and no probleme	F 25	Please see at	hachad	8-17-16 8-17-16
		6 at 12:30 p.m. revealed Id no towels or washcloths		, i		
	Interview on 5/13/16 a stated there is never a	l 12:30 p.m., Resident #1 ny clean towels or	-			
ORM CM8-2567	(02-99) Previous Versions Obsol	ete Event (D:0JLG1	1 F	 scility ID: IA0948 [j	continuation sheet P	

Aug. 5. 2016 2:43PM All American Care

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No. 2041 P. 20/27

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/05/20 FORM APPROVE OMB N <u>O, 0938-039</u>
STATEMENT	DF DEFICIENCIES F GORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		165453	B. WING	,	06/23/2016
	ROVIDER OR SUPPLIER ALLEY REHABILITATION	& HEALTHCARE CENTER O	60	REET ADDRESS, CITY, STATE, ZIP CODE 1 E POLK ST ASHINGTON, IA 52353	
(X4) (D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION))D PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION 8) CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 254	them every day from available, they are no for use in room. 2, The MDS dated 4/ #3's diagnoses includ diabetes mellitus. The with a BIMS score of resident with no short problems and no pro- daily decision making	e 28 m. The resident has to get the selves, if they are over passed out to residents 01/16 identified Resident led Parkinson's disease and a MDS revealed the resident 14 out of 15, indicating the t or long term memory plems with cognitive skills for a skills. The MDS identified supervision and setup assist	F 254	Please Dee atti	8-17-16
F 279 SS=D	of one staff for dressi hyglene. Observation on 5/20/ Resident #3 having in the residents room. When Interview on 5/ #3 stated towels and passed out to use in stated he/she will go at times there are noi 483,20(d), 483,20(k)(COMPREHENSIVE (A facility must use the to develop, review and comprehensive plan The facility must develop plan for each residen objectives and timeta medical, nursing, and	ng, ealing, and personal 16 at 7:50 a.m. revealed o washcloths or towels in 20/16 at 7:50 a.m., Resident washcloths are never their room. Resident #3 and get them from staff and ne available. 1) DEVELOP CARE PLANS a results of the assessment d revise the realdent's	F 279	please See attac	8-17-h

FORM CM3-2567(02-99) Previous Versions Obsolete

Facility ID: 1A0948

If continuation sheet Page 29 of 98

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No. 2041 P. 21/27

		D HUMAN SERVICES MEDICAID SERVICES	-		PRINTED: 06/05/2016 FORM APPROVED OMB NO: 0938-0391
TATEMENT (of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) PATE SURVEY COMPLETED
		165453	B. WING		06/23/2016
NAME OF P	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CODE	1 0012012010
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O	4	E POLK ST BHINGTON, IA 52353	
(X4) (D PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS REFERENCED TO THE APPR(DEFICIENCY)	LD BE COMPLÉTION
F 279	Continued From page	29	F 279	-	8-19-16
	to be furnished to alla highest practicable ph psychosocial well-bein §483.25; and any sen be required under §48 due to the resident's e			Please See attac	had
	by: Based on observation interviews, the facility comprehensive care p residents reviewed (R facility reported a cene Findings include: 1. According to the 3/ (MDS) assessment, R Impaired cognition, an while eating. The resis non-Alzheimer's deme diabetes mellitus. Review of current care of the resident had a s to eating food too fast interventions directed	failed to follow blans for 3 of 27 current esidents #4, #6, #7). The sus of 60 residents. 10/16 Minimum Data Set esident #4 had moderately d required supervision dent's diagnoses included entia, a seizure disorder and e plan revealed a focus area swallowing problem related . The care plan staff to make sure the	5	De atrac	
	teaspoon for ealing, d were directed to instru- upright position, to eal bite thoroughly. The s monitor/document/rep symptoms of dysphag coughing, drooling, ho	ort as needed any signs or			

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	RE & MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185453	B. WING		06/23/2016
NAME OF PROVIDER OR SUPPLIE	Ŕ		STREET ADDRESS, CITY, STATE, ZIP CODE	
PEARL VALLEY REHABILIT	ATION & HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353	
PREFIX (EACH DEF	NY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL IY OR LSC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
resident receive paper plates du due to increase The Care Plan direc diot as ordered staff to serve fo Record review of dated 2/25/16 ft Pathologist reve degrees, food to per bite, alterna Record review of from the Dieticla assessed reside Recommendatii liquids, no more time, alternate v right. The Speech Th 2/24/16-Reside (ST) treatment aspiration. Res through 3/7/16 v discussed with use of safe swa in a safe and tir on the important with chin tuck, s swish to decrea PO Intake. Interview on 6/2 Development C sheets for each the residents bu		F 27	» Please See attached	ş. 19.16

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: 1A0948

If continuation sheet Page 31 of 98

Aug.	5.	2016	2:43PM	A11	American	Care
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P 22/27 No 2041

DEHARTMENT OF HEALTH AND HUMAN SERVICES FORM APPRO CENTERS FOR MEDICARE & MEDICALD SERVICES OWN MERCINES STREEMANG CORRECTION In Distribution MARER AND FLANCG CORRECTION In Distribution MARER MALE OF PROVIDER ON SUPPLIER 16543 MALE OF PROVIDER ON SUPPLIER 16543 PARL VALLEY REHABILITATION & HEALTHCARE CENTER O STREET ADDRESS, CITY, STATE, 2P CODE PARL VALLEY REHABILITATION & HEALTHCARE CENTER O STREET ADDRESS, CITY, STATE, 2P CODE PARL VALLEY REHABILITATION & HEALTHCARE CENTER O STREET ADDRESS, CITY, STATE, 2P CODE PARL VALLEY REHABILITATION & HEALTHCARE CENTER O STREET ADDRESS, CITY, STATE, 2P CODE PARL VALLEY REHABILITATION & HEALTHCARE CENTER O STREET ADDRESS, CITY, STATE, 2P CODE PARL VALLEY REHABILITATION & HEALTHCARE CENTER O PREVEX PARL VALLEY REHABILITATION & HEALTHCARE CENTER O PREVEX PARL VALLEY REHABILITATION & HEALTHCARE CENTER O PREVEX PARL VALLEY REHABILITATION & HEALTHCARE CENTER O PREVEX BARNAGY STREEMANTON DO NORMARY PREVEX VALUE VALUE PREVEX BARNAGY STREEMANT ON DISCOMMENTON DO NORMARY PREVEX VALUE VALUE PREVEX BARNAGY STREEMANTON DO	Aug	. 5. 2016 2:43	PM – All American Care	;	· No. 2041	P. 23/27
FIXTEMENT OF DESIGNATES (M) PROVIDENSUPERALATION A HEALTHCARED NUMBER (D) DATE SUMMEY (D) DATE SUMMEY INSELENCE OF CONSTRUCTION 105493 105493 0						PRINTED: 08/05/201 FORM APPROVE OMB NO: 0938-039
NAME OF PROVIDER ON SUPPLIER International and the second secon	STATEMENT O	of deficiencies	(X1) PROVIDER/SUPPLIER/CLIA	1		
NAME OF PROVIDER ON SUPPLIER STREET ADDRESS, GITY, STATE, 2IP GODE dot is Polick st water in the intermediate of the content o	·		165453	Ś. WING		06/23/2016
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O EDI E POLK ST WASHINGTON, IA 52353 PHERK TOB SUMMAY STATEMENT OF DEFICIENCES (EACH OPRICENT ALTOR ACTION ABOULD BE (EACH OPRICENT ACTION ABOULD BE CROSS REFERENCE OT OT EACH PRESK OWNED (EACH OPRICENT ACTION ABOULD BE CROSS REFERENCE OT OT EACH PRESK OWNED (EACH OPRICENT ACTION ABOULD BE CROSS REFERENCE OT OT EACH PRESK OWNED (EACH OPRICENT ACTION ABOULD BE CROSS REFERENCE OT OT EACH PRESK OWNED (EACH OPRICENT) ACTION ABOULD BE CROSS REFERENCE OT OT EACH PRESK OWNED (EACH OPRICENT) ACTION ABOULD BE CROSS REFERENCE OT OT EACH PRESK OWNED (EACH OPRICENT) ACTION ABOULD BE CROSS REFERENCE OT OT EACH OPRICENT ACTION ABOULD BE CROSS REFERENCE OT OT PRESK OWNED (EACH OPRICENT) ACTION DEFICIENCY OWNED (EACH OPRICENT) DEFICIENCY DEFICIENCY OWNED (EACH OPRICENT) DEFICIENCY OWNED (EACH OPRICENT) DEFICIENCY OWNED (EACH OPRICENT) DEFICIENCY DEFICIENCY OWNED (EACH OPRICENT) DEFICIENCY DEFICIENCY OWNED (EACH OPRICENT) DEFICIENCY DEFICIENCY OWNED (EACH OPRI	NAME OF P	ROVIDER OR SUPPLIER		8	TREET ADDRESS, CITY, STATE, ZIP CODE	
Priority Tx0 reaction processory with the precedence processory with result. ATORY OR LSC IDENTIFYING INFORMATION PREFX Tx0 reaction and control approximate result. The approximate and the precedence processor result of the approximate and the approximate and the precedence of coses repretences or the approximate and the approximate processor and the approximate and the approximate and the approximate and the approximate and the approximate and the approximate and the sheets for 2 residents. F 279 F 279 F 279 F 279 2. The MDS dated 6/6/16 revealed Resident #6 had diagnoses that included non-Alzheimer's dementia, had severe cognitive impairment with symptoms of delivin, require extensive assistance by 2 or more stelf members for transfers to and from bed or ohair, bathing, tolleting, dressing and personal tyglene, and supervision with set-up assistance required for eating. PALL Automation Resident #6's nursing care plan included a problem identified as Activities of Daily LMing (ACL) self-care performance delicit, with B10/016 good the resident would maintain current twel of function in ADL's, and interventions that included: 1. Provide finger foods when the resident has difficulty using utensits. A 5/12/16 progress note transcribed by the facility Detelent statict: resident targuing in assisted dining room which is more quiet, resident has adden weight loss of 7.8 parcent, weight loss began when resident moved from the assisted dining room to the metia individention the assisted dining room and laboratory work first included a complete medical profile and pre-albumin. The note was sent to the physician cont with signature A diff with signature			N& HEALTHCARE CENTER O			
 P278 Collimiter From page 31 P278 Collimiter From page 31 P278 were no sheets. Hell 2 contained only task sheets for 2 residents. 2. The MDS dated <i>Elör</i>/6 revealed Resident #6 had diagnoses that included non-Atzhelmer's domenta, had severe cognitive impairment with symptoms of delivium, required extensive assistence by 2 or more steff members for transfers to and from bed or chair, bathing, tolletho, dressing and personal hyglene, and supervision with set-up assistance required for eating. Resident #6's nursing care plan included a problem identified as Activities of Deliy Living (ADL) self-care performance delicit, with 6/10/16 goal the resident would maintain current level of function in ADL's, and Interventions that included: Provide finger foods when the resident has difficulty using utensits. The resident requires supervision/limited assisted dining room which is more quiely resident has sated: resident basisted dining room which is more quiely resident has sated fining room which is more quiely resident has began weight loss of 7.8 percent, weight loss began weight loss of 7.8 percent, weight loss began weight loss of a percent, weight loss began weight loss of the resident hat included a complete medical profile and pre-siburin. The nole was sent to the physician by facsimile (fax), the physician confirmed the order with signature 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR	DE COMPLETION
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	F 279	went to obtain the tar were no sheets. Ha sheets for 2 resident 2. The MDS dated 5 had diagnoses that it dementia, had seven symptoms of delirium assistance by 2 or m transfers to and from tolleting, dressing an supervision with set- eating. Resident #6's nursing problem identified as (ADL) self-care perfor goal the resident wor function in ADL's, an 1. Provide finger food difficulty using utensi 2. The resident requi assistance by 1 staff A 5/12/16 progress n	sk sheets in Hall 1 but there II 2 contained only task s. //6/16 revealed Resident #6 included non-Alzheimen's e cognitive impairment with n, required extensive ore staff members for bed or chair, bathing, d personal hygiene, and up assistance required for g care plan included a Activities of Daily Living immance deficit, with 8/10/16 uid maintain current level of d interventions that included: fs when the resident has is. res supervision/limited to eat.	F 279		od
the physician confirmed the order with signature		room which is more of better in last 3 weeks weight loss of 7.8 per when resident moved room to the main dial resident to continue of room and laboratory complete medical pro-	ulet, resident has eaten in that environment, 90 day rcent, weight loss began it from the assisted dining ing room. Recommended eating in the assisted dining work that included a pille and pre-albumin. The		Г — — — — — — — —	
and returned the faxed document on 5/17/16. Observations of the resident revealed:		the physician confirm and returned the faxe	ed the order with signature ad document on 5/17/18.			

FORM CMS-2587(02-99) Previous Versions Obsolela

Facility ID: 1A0948

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If continuation sheet Page 32 of 98

		D HUMAN SERVICES MEDICAID SERVICES			FORM APPROV
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT(F(CAT)ON NUMBER;	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X9) DATE SURVEY COMPLETED
		165453	B. WING	:	0010010040
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	06/23/2016
		& HEALTHCARE CENTER O	6	VASHINGTON, IA 52353	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUET BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRÓVIDER'S FLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
F 279	Continued From page	32	F 279		8-17-
	6/21/16 at 7:55 a.m., 4 room, without food or	sealed in the main dining beverages,			
	room, silverware wrap in front of the resident cereal, toast, 2 slices eggs, uneaten. 6/21/16 at 8:43 a.m., 1 main dining room tabl eyes closed, sliverwar napkin, had not eaten assistance by staff.	seated in the main dining oped in a napkin, breakfast t that included a bowl of hot of bacon and scrambled remained seated at the e, slümped forward with re remain wrapped in a any food presented and no		Please see attached	
	dining room table, silv napkin, no assistance dishes removed from resident remained in the 10:14 a.m. when the r	ward in the chair at the erware wrapped in a by staff, uneaten food and the lable at 9:12 a.m. The he dining room chair until nurse practilloner asked a CNA) to assist her to take			
	resident seated in the last of those seated in Dietary staff delivered provide set-up assista were not in the dining Observation on 6/24/1 resident remained sea silverware remained w resident had not eater	the meal and did not nce for the resident, CNAs room. 6 at 8:40 a.m. revealed the ted in the dining room, rapped in a napkin and the a any of the food presented. 6 at 8:52 a.m. revealed the			

Aug.	5.	2016	2:44PM	A]	American	Care
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No. 2041 P. 25/27

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICE	S				PRINTED: 0 FORM AF	PROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA		CONSTRUCTION		(X9) DATE SUR COMPLET	VEY
		165453		B. WING	r		06/23//	2016
	ROV/DER OR SUPPLIER	& HEALTHGARE CEN	TER O	6	TREET ADDRESS, CIT D1 E POLK ST /ASHINGTON, IA			-
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencie Y must be preceded by LSC identifying inform/	FULL	id Prefix Tag	(EACH CO	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD F FERENCED TO THE APPROPRI DEFICIENCY)	-	(XG) DMPLETKON DATE
F 279	Continued From page napkin, the resident I staff cleared the table During Initial resident a.m., the Director of I resident yelled when to redirect the residen quiet in order for the During an interview of Dieticlan stated the re- to eat and if the facilit dining room that staff assistance as needed meal-time. 3. Resident #7 had a Assessment with a re- to a significant chang resident had diagnos hypertension (high bi non-Aizheimer's dem severe cognitive imp- delirium, and required or more staff membe bed and chair, bathin personal hyglene. Ti resident had daily be others. A MDS Assessment with 5/20/16 indicated the extensive assistance for transfers to and fi dressing, tolleting an identified the residen behaviors that were of daily behaviors not d	and not eaten as the operation of the eaten as the eaten and the resident at the eaten and hip fracture as for transfers to and operation, to the eaten and hip fracture as for transfers to and extensive assistance as for transfers to and the eaten at the eaten and hip fracture as for transfers to and the eaten at the eaten and hip fracture as for transfers to and the eaten and hip fracture as for transfers to and the eaten and hip fracture as for transfers to and the eaten and hip fracture as for transfers to and the haviors not directed at the haviors not directed at the haviors and the transfers to and the personal. The MDS tables are and the personal. The MDS tables are and the personal. The MDS tables and the tables and tables and the tables and tab	2:05 (the equired a t was h, the stance isted rovide MDS) /16 due ad the mia, bs of ze of 2 I from and at of minued embors thing, al	F 279	Plea	2Al attached		17-16
ÉÓRM ÓNS-26	B7(02-99) Previous Versions Ob		Event (0:0)LG11	Fa	cility 1D: TA0948	If contin	uation sheet Pa	ge 34 of 98

TATEMENT (F DEFICIENCIE8	KIN PROVIDER/SUPPLIER/CLIA	1`'	PLE CONSTI		(X3) DA	<u>VO. (1938-039</u> TE SURVEY MPLETEO
ND PLAN OF	CORRECTION	μερι (Εβλι μια ματιρα.	A. BUILDIN	A. BUILDING			
		165453	B. WING				6/23/2016
NAME OF PL	ROVIDER OR SUPPLIER				ODRESS, CITY, STATE, ZIP CODE		
PEARL VA	LLEY REHABILITATIO	N & HEALTHCARE CENTER O		601 E PO. WASHIN	LK ST IGTON, IA 52353		
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E 070	Continued From pa	ao 94	F2	70			8-17-16
	problem identified a (ADL) self-care def resident to maintain and interventions th 1. Assist of 1 to 2 fo 2. Floor alarm with 5/28/16. 3. Sling to left arm 4. Extensive assists initiated 12/30/15. 5. Limited assistan- initiated 2/28/16. 6. Supervision/assist initiated 2/28/16. 7. Limited assistan hygiene and oral co 6. Limited assistan revised on 2/28/16	or transfers, initiated 5/6/16, pad for safety, initiated at all times, initiated 6/20/16, ance by 1 staff for showers, ce of 1 staff for dressing, stance of 1 staff for eating, ce of 1 staff for personal are, initiated 2/28/16, ce of 1 staff for tollet use,			Please See attache	ed	
	Another Care Plan problem Identified was a fall with serious Injury related to an unsteady galt, 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.						
	with dementia, wild would be able to co daily basis, and int 1. Cue, reorient an initiated 2/28/16. 2. Keep the resider	problem identified the resident o 8/9/16 goal that the resident ommunicate basic needs on a erventions that included: d supervise as needed, nt's routine consistent and try nt care givers as much as	-				

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CENTER	<u>\$ FOR MEDICARE &</u>	ND HUMAN SERVICES	0/05-1110		OMB NO	M APPRO\ <u>D. 0938-0</u> = SURV&Y
	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		PLETED
		165453	B. WING		06	/23/2016
	ROVIDER OR SUPPLIER	N & HEALTHCARE CENTER O		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E POLK ST WASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC)DENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLE DATE
F 279	resident's needs, ini 4. Present just one to command at a time, The resident's recom The incident/Accider 5/30/16 at 1:45 p.m. the floor beside the inter- The report indicated disoriented as was prevere identified and to The report indicated disoriented as was prevere identified and to The Incident/Accider 5/31/16 at 1:00 p.m. on the floor on back when the nurse atter The report indicated the facility sent the r resident had a diagr humerus (upper arm facility later the sem Observations of the following: On 6/20/16 at 12:29 back in bed with door yells "I need help, in were audible 4 resid Resident #7's room. On 6/21/16 at 6:05 a room was closed an a.m. when a certified	ions in order to determine the liated 2/28/16. hought, idea, question or initiated 2/28/16. d indicated the following: int Report form identified on , staff found the resident on bed and lying on left side. i the resident as confused and orior to the fail. No injuries the fail was unwitnessed. Int Report form indicated on , the staff found the resident in room. The resident yelled impted to assess the left arm. I the fail as unwilnessed and resident to the hospital. The nosed of a fractured left in borne) and returned to the e day. resident identified the in rooms away from a.m., the door to the resident's id remained closed at 6:08 d nursing assistant (CNA) in the room with the resident.	F 27	Please see attac	thed	8-17-
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N₀.2042 P. 1/31

		D HUMAN SERVICES				FO OMB	TED: 08/05/2016 IRM APPROVED NO: 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		DNSTRUCTION		ate Survey Impleted
		165453	B. WING				06/23/2016
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		601	EET ADDRESS, CITY, STATE, ZIP CODE E POLK ST SHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y must be preceded by full .sc identifying information)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) Completion Date
F 279	hall of Resident#7 's Staff K stated she did after lunch and did no resident's door was c could hear the bed al the resident yelled for resident's room after opened the door and floor, on back and blo she stayed with the resident's too hear the Staff K stated the resi frequently. Staff K st didn 't like to hear it is Staff K stated she ha repeated occasions is resident's door becau resident's door becau	of Resident#7 's room on 5/31/16 day shift. ff K stated she did not put the resident in bed or lunch and did not know who did. The Ident's door was closed and she stated she ident's door was closed and she stated she ident's door was closed and she stated she ident's room after lunch. Staff K stated she one of the door and found the resident on the or, on back and blood on arm. Staff K stated o stayed with the resident and yelled for help. If K stated the resident called out or yelled quently. Staff K stated the residents and staff n 't like to hear it and shut Resident #7's door. If K stated she had instructed staff on eated occasions they should not shut the ident's door because they could not hear the ident's alarms or calls for help when needed. If K stated the resident didn't use [activate] the		= 279 Plaase Ale atta		ached	8-17-16
	position the resident wall) in order to decr hallway. Staff Q stat CNA's that they shot door as they could ne help. On 6/22/16 at 5:40 p	on his/her left side (faced the ease the noise audible in the ed she instructed other old not shut the resident's ot hear the resident's calls for .m., Staff H, LPN (licensed unit manager, stated the			•		
FORM CMS-2	67(02-99) Previous Versions Ob		311	Façili	ity ID: 1A0948	lí continuation a	sheet Page 37 of 9

No. 2042 P. 2/31

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	DE DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		<u>VO, 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	1			MPLETED
		165453	B. WING	······································		6/23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET AODRESS, CITY, STATE, ZIP C	CODE	
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X6) COMPLETI DATE
						8-17-
F 279	resident's door was o the room. Staff H sta	ften closed without staff in Ited she had instructed the	F 27	9		0
	staff continued to leave	ose the resident's door and ve the resident in the room losed after instructed not to.		DIMAN		
	worked the 6:00 p.m.	m., Staff J, LPN, stated she to 6:00 a.m. shift, often toor closed without staff in		flease see at	fached	
	the room, she opener staff to leave the doo	d the door and instructed r open at least a few inches larms and resident's calls for				
	help, and was an ong residents that lived in	joing battle with the i the same hall, Resident #7				
		her residents didn't like lhat. Ident would not use the call				
	Interviewed and slate	.m., Staff F, CNA, was ad she had worked on the years. Staff F stated the				
	resident always calls check on the residen often altempted to ge	d out at night and staff would t frequently, as the resident et up on their own. Staff F	a			
	stated atter sne/ne bi needed at least 1 sta sland.	roke their hip, the resident ff person for support to				
	nurse stated she wor 5/31/16 and respond	a.m., the MDS coordinator ked on the day shift on ed to the resident's fall. The				
	on the floor near the floor. The bed alarm	e resident was on their back sink and no malt fay on the was audíble and hadn't MDS nurse staled Staff H				
/	was in the room with which CNA).	a CNA (didn ' t remember	F 28			
F 281	483.20(K)(3)(I) SERV	ICES PROVIDED MEET	F28	" Alexandre has all	allo 1	12.12

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FORM CMS-2567(02-99) Previous Varaions Obsolate

Facility ID: 1A0946

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If continuation sheet Page 38 of 98

Aug.	5.	2016	2:46PM	A11	American	Care

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No. 2042 P. 3/31

CENTER	S FOR MEDICARE &	ID HUMAN SERVICES	0/3 k0 87	101 5 6	ONSTRUCTION	FOR OMB N	ED: 08/05/2010 MAPPROVEI <u>O. 0938-039</u> E 0119/162
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			(X3) DATE SURVEY COMPLETED	
		165453	B. WING		····	00	3/23/2016
	ROVIDER OR SUPPLIER	& HEALTHGARE CENTER O	·	601	EET ADDRESS, CITY, STATE, ZIP CODE E POLK ST SHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-RÉFERENCED TO THE APPROP DEFICIENCY)	TION SHOULD BE CON THE APPROPRIATE	
F 281	Continued From page	÷ 38 '	F:	281			8.17.16
SS≃D	PROFESSIONAL ST	ANDARDS		-			0
		d or arranged by the facility al standards of quality.					
	by: Based on observatio Interviews, the facility orders for 1 of 27 curi	is not met as evidenced n, record review, and failed to follow physician's rent residents reviewed, sility reported a census of 60			Please See attache	d	
	Fíndings include:						
	assessment, Resider disorder, mainutdilon The MDS identified if memory and required hygiene. Observation on 6/21/ Resident #5 had a g-1	16 Minimum Data Set (MDS) It #5 diagnoses of seizure and a heart malformation, he resident with Intact I extensive assistance with 16 at 6:46 am revealed lube (gastric tube for		S			
	Practical Nurse (LPN) an appointment which Staff G indicated the	a.m. Staff G, Licensed), reported Resident #5 had o usually lasted 3-4 hours. evening shift would need to a when the resident returned					
	Review of Resident # Discharge Summary been placed on 3/14/ experiencing dysphag secondary to a stroke	documented the g-tube had 16, due to the resident gla (difficulty swallowing) 5. The documentallon (olerated a mechanical soft					

FORM CMS-2687(02-99) Previous Versions Obsolete

Event ID: 0JI.G11

Facility ID: IA0848

If continuation sheet Page 39 of 98

	Aug.	5.	2016	2:46PM	A11	American	Care
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1/21 No 2042 p

	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		165453	B. WING	······	06/23/201
•	PROVIDER OR SUPPLIER	I & HEALTHCARE CENTER O		STREET ADDRESS, CITY, STATE, 21P CODE 601 E POLK 6T WASHINGTON, IA 52353	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF OFFICIENCIES AY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLI
F 281	Review of the current g-tube in place but no or nutrition support at The Physician's Orde staff to flush the g-lut (milliliter) of tap water Review of the Medica (MAR) on 6/22/16 at flush order signed as the month of June 20 documentation area p MAR revealed no refu documentation.	t plan of care revealed the of used/needed for hydration t this time. Form dated 6/16 directed be every day with 60 ml r. ation Administration Record 10:49 am revealed the water provided 11 of 22 days for 16. Review of the provided on the back of the usal or omission	F 2	Please See attache	8-17
F 309 SS≂G	HIGHEST WELL BER Each resident must re provide the necessary or maintain the higher mental, and psychoso	NG sceive and the facility must y care and services to attain st practicable physical,	F 3		10 Me 7-216
	by: Based on observation Interviews, and review the facility failed to ap implement intervention physician appointment physician's appointment cancer and provide tra- for post blopsy site (R resident with a changer #10). The sample con-	Is not met as evidenced n, record review, staff w of facility documentation, opropriately assess end ns for 1 resident following a nt, continued follow-up ent for treatment of skin eatments for skin treatment Resident #27) and for 1 e of condition (Resident nsisted of 27 residents and census of 60 residents.		flease Die attache	d

FORM CM3-2567(02-99) Previous Versions Obsolete

Event (D:0JL@fi

Facility ID: 1A0946

If continuation sheet Page 40 of 98

PREFX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LGC IDENTIFYING INFORMATION) PREFX TAG CLOBER REFERENCED TO THE APPROPRIATE DEFICIENCY) F 309 Continued From page 40 F 309 F 309 F 309 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 find 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, Itransfers, ambutation end tollet use, and required staff supervision for dressing, eating, and Authouse	(X6)
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 601 E POLK ST WASHINGTON, IA 52353 CONTINUER OF DEFICIENCIES ID PRAIL VALLEY REHABILITATION & HEALTHCARE CENTER O SUMMARY STATEMENT OF DEFICIENCIES OF 100 PREVIX REAL OF CORRECTION ALLOY DEFICIENCIES TAG PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION TAGE TO THE APPROPRIATE CONSTRUCTION SHOULD BE PROVIDERS PLAN OF CORRECTION TAGE TO THE APPROPRIATE TREET ADDRESS, CITY, STATE, ZIP CODE 601 E POLK ST WASHINGTON, IA 52353 PROVIDERS PLAN OF CORRECTION PREVIX TO SUMMARY STATEMENT OF DEFICIENCES ID PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION </th <th>(X6) 2014年1月17日</th>	(X6) 2014年1月17日
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, OTY, STATE, ZIP CODE PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O STREET ADDRESS, OTY, STATE, ZIP CODE OK4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D PREVIEW PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D PREVIEW PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D PREVIEW PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D PREVIEW PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D PREVIEW PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D PREVIEW PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D PREVIEW PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D PREVIEW PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D PREVIEW PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D PREVIEW PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D PREVIEW PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG D PREVIEW PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY) D PREVIEW PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY) D PREVIEW PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY) PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY) D PROVIDERS PLAN OF CORRECTINES (CONFLETIO
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O 601 E POLK ST WASHINGTON, IA 52353 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIST BE PRECEDED BY FULL TAG ID PREFIX TAG PREFIX TAG PREFIX TAG PREFIX (EACH DEFICIENCY) IC PREFIX TAG PREFIX TAG	CONFLETIO
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OKADIC SUMMARY SINEBER (COUP DE TELEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CEACH COGRECTIVE ADDITION SHOULD BE CROBS-REFERENCED TO THE APPROPRIATE DEFICIENCY Ceach connective ADDITION SHOULD BE CROBS-REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 40 F 309 F 309 Continued From page 40 F 309 F 309 F 309 Z 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, Itansfers, ambutation and tollet use, and required staff supervision for dressing, eating, and All All All All	CONFLETIO
F 309 Continued From page 40 F 309 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 cognilive Impairment. The MDS indicated the resident to be independent with bed mobility, transfers, ambulation and tollet use, and required staff supervision for dressing, eating, and	DATE
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 some on the right temple, crusting spot on right forehead, and rash on face. The plan consisted of a shave biopsy to the area of	9-316-1L

	FOR MEDICARE &	MEDICAID SERVICES	(X2) MULTIPLE CA		B NO. 0938-039
ND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		168453	B. WING		06/23/2016
NAME OF PE	OVIDER OR SUPPLIER		STR	RET ADDRESS, CITY, STATE, ZIP CODE	
PEARL VA	LLEY REHABILITATION	I & HEALTHCARE CENTER O		E POLK ST SHINGTON, IA 52353	
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES SY MUST HE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X8) COMPLETIO DATE
F 309	preserve the tempor cranial nerve. On 2 informed of patholog	e 41 servation and to try and al branch of the seventh /29/16 the resident was ly results and the need for used. The Mohs surgical	F 309		7-06-1
	procedure was arrar Review of the derma 3/28/16, Indicated th s office and reported unable to make the derma the Mohs surgical pro- reschedulad the app Review of the derma 4/11/16, Indicated the the facility to make a to make the schedur administrator inform already left that work appointment thus the	aged for 3/7/16. atologist physician note dated a facility called the physician ' a Resident #27 to be III and scheduled appointment for rocedure today. The facility pointment for 4/11/16. atologist physician note dated appointment - soffice called sure Resident #27 was going led appointment. The facility ad the physician the bus had add take the resident to the e resident is unable to make	4	Please Dec attached	
	the appointment age made for 4/18/16. T frustration with the f is the third time the s surgery been miss informed the physic	ain. A new appointment was he physician discussed his aclilly Administrator that this coordination for the resident ' aed. The Administrator ian that she would personally resportation for the 4/18/16		·	
	Review of the derm 4/14/16 indicated th from the facility info provide transportati scheduled appointm	atologist ' s note dated le physician received a call rming him they are unable to on for Resident #27 tent on 4/18/16. The physician sident ' s appointment for			
	5/2/16. The physicle importance of keep it has been resched	an stressed to the facility the Ing this appointment because luled now five times. hatologists physician note	i i		

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED; 00/05/ FORM APPRO <u>OMB NO: 0</u> 938-0
	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		165453	B. WING		06/00/06
NAME OF PI	ROVIDER OR SUPPLIER	•	ŞTRI	ET ADDRESS, CITY, STATE, ZIP CODE	06/23/2016
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		e polk st Shington, IA-52353	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL L&C IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LO BE COMPLET
F 309	Continued From page	ə 42	F 309		7.26.
	office staff that their of cancelled the appoint this as false. The phy spoke with the Admin resident had surgery i 4/29/16 and she is un had the procedure do why this physician ha resident would not be appointment with this indicated that it is so of coordination of oare w resident; the physician resident is primary ca coordination of the resident coordination of the resident indicated the physician resident 's primary ca coordination of the resident coordination for the the Review of the physician Resident #27 primary the resident sent to an treatment of a skin less of how the resident en- 's office for treatment physician had not refe treatment. On 5/2/16 the dermatic Resident #27, and indi-	ment. The note identified sician documented he istrator who said the at another location on aware of why the resident ne at the other location or d not been notified that the attending the scheduled physician. The physician difficult to get proper with the facility for the n decided to phone the tre physician office for sident 's care of the skin cannot coordinate resident. an note dated 5/9/16 n received a call from care physician indicating tother physician for ion and they are unaware ded up at another physician as the primary care med the resident for that as the primary care med the resident was valing lesion of the right vealed a basal cell		Please See attalhed	
1	four separate times for turner to be performed surgical date has been				
		w. Most recently, Resident show up today, May 2nd at	-	с.	

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No. 2042 P. 8/31

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FORM	APPR	OVED
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		ID HUMAN SERVICES MEDICAID SERVICES		-			MAPPROVED 0. 0938-0391
STATEMENT C	or deficiencies Correction	(X1) PROVIDER/SUPPLIER/CL)A IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		165453	B. WING			06	/23/2016
NAME OF P	ROVIDER OR SUPPLIER		I		REET ADDRESS, CITY, STATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353			
(X4) ID PREFIX TAG	(EACH DEFIC)ENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		d Be	(X6) COMPLETION DATE
F 309	8:00 a.m. for the proceedure Resident #27 not trans office for the procedure physician 's office car appointment. The phy completely untrue. The resident had some sor performed on Friday physician indicated of for the resident 's bar another procedure. The the above difficulties phoned the resident 's bar another procedure. The the above difficulties phoned the resident 's office and reported the facility. The physician not had the basal cell exclsed, then the resident office informed the d into this and report work care for the resident Review of Resident at indication of follow at or rescheduled. Review of Resident at indication of a lesion been present for 5 y bleeds occasionally The resident reports biopsied in the past. resident 's primary of indicated per their re had a biopsy of the r performed, wound in follow-up in 6 month	adure. Once again, hisported to the physician 's ire. The physician 's office ad the facility claimed the alied and canceled the sysician indicated this is the facility claimed the ort of surgical procedure at another location. The sol having any idea if it was usal cell carcinoma or the physician indicated with in mind, the physician 's primary care physician 's us frustrations with the in indicated if the resident has if carcinoma surgically ident needs to have this ansportation is not such a imary care physician 's ermatologist they will look when this gets arranged to 's problem. #27 Visit Summary dated poolntments being scheduled #27 Visit Summary dated e resident presents in mary care physician for in on the right temple that has ears. The resident reports it bleeds and sometimes hurts. that it may have been The physician office and they incords, the resident has never ight temple. A shaved blopsy estructions given, resident to is or sooner pending biopsy		309	Mease set actions		7-26-16
FORM CMS-25	87(02-99) Previous Versions Of	isofela Event i O: 0.1L	.611	fв	sliky ID: IA0948 If co	nunuation she	ar hage 44 or at

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PRINTED: 08/05/2016
FORM APPROVED
OMB NO 0038-0301

		D HUMAN SERVICES				RM APPROVED IO. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL/A			(X2) MULTIPI	(XS) DAT	(XS) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A, BUILDING		COM	(PLETED
		165453	B. WING		0	6/23/2016
NAME OF PI	ROV/DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		& HEALTHCARE CENTER O		601 e polk st		
			-	WASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENYIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION 8H/ CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X6) Completion Date
	Continued From page results. An addendum the pathology results and a facility nurse. T cell carcinoma, with h associated with squar proliferation with featu and adjacent scar. Th facility has not been p physician spoke with confirmed that wound performed for the last stressed the importar and reiterated the ins the nurse agreed to fin nurse does not think i surrounding redness physician indicated th surgery, the facial loo conservation is criticat the risks, benefits and repair options that are lesion has been exclas surgical defect may b evident by lesion. Review of Resident # Indication of the phys the facility, or any sur scheduled for the rea An interview was con p.m. with Staff FF, Re Fif stated she received	a 44 a dated 5/3/2016 Indicated were relayed to the resident he pathology revealed basal infiltrative features, matized epidermal ures of seborrheic keratosis, he resident reports that the performing wound care. The the facility nurse, who a care has not been a couple days. The physician nee of proper wound care tructions of wound care, and he area tooks infected; no or purulent drainage. The he resident to undergo Mohs attom where tissue d, The physician discussed d alternatives as well as a often uncertain until the ted, discussed that the e larger than the clinically 27 clinical record taoked ician 's conversation with glcal appointment being		CROSS-REFERENCED TO THE APP DEFICIENCY)		7-26-16
	biopsy done to the left stated she told the ph done a couple month did not document this 's clinical record. Sta	f the resident has had a It temple lesion. Staff FF systclan the resident had one s ago. Staff FF stated she conversation in the resident off FF stated she did not d missed the follow-up			۰. 	

PORM CMS-2587(02-99) Previous Versions Obsolete

Facility ID: (A0946

If continuation sheet Page 45 of 98

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No. 2042 P. 10/31

- DEPARTI		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/05/2016 FORM APPROVED OMB NO. 0938-0391
SYATEMENT (FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		165453	B. WING		06/23/2016
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O	6(TREET ADDRESS, CITY, STATE, ZIP CODE D1 E POLK ST VASHINGTON, 1A 52353	
(X4) ID PREFIX TAG	(EAGH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEF[CIENCY]	LO BE CONPLETION
F 309	stated noting was do appointment calenda the appointments or ri- FF stated she was no appointments or the surgery from the resi- until the surveyor as stated she did not kin talked to on 4/29/16, physician, and nothin stated she would exp Staff FF further state appointments fell the 2. Resident #10 had date of 5/27/16. The Resident #10 which dementia, anxiety di- schizophrenia, and s MDS stated the resid assistance of 1 staff personal hyglene, ar and set up assistand toilet use. The MDS inattention, disorgan verbal behavioral sy others, and other be directed toward other resident's BIMS (Bri score as 13. A score problems. An Incident report for identified the resider staff attempted to cal had a 0.5 cm (centin	from 2/16/16. Staff FF cumented on the r or the resident 's record of why they got canceled. Staff obt aware of the missed follow-up appointment for dent 's 4/29/16 appointment ced about them. Staff FF ow who the physician, she although she spoke with the ng documented. Staff FF poet staff to document this. d the resident 's bough the cracks.	F 309	Please See attach	7:26-16
FORM CMS-2	the forehead. 67(02-99) Previous Versions Ol	sciete Évent 10:0JL	911 Fr	actility ID: 1A0948 If c	xonlinuation sheet Page 46 of 98

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No. 2042 P. 11/31

PRINTED: 08/05/2016
FORM APPROVED

	MENT OF HEALTH AN						FORM APPROV DMB NO. 0938-03	ΈD
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		165453	1	8, WING	······································		06/23/2016	
NAME OF PI	ROVIDER OR SUPPLIER	L			TREET ADDRESS, CITY, STATE	ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENT	ER O		DI E POLK SY JASHINGTON, IA 52353			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Atement of Deficiencies Y Must be preceded by F LSC Identifying Informat	ขแ	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BI IO TO THE APPROPRIA ICIENCY)		ж
F 309	Continued From page A Progress Note for F at 8:49 a.m., indicate area located on the ri The notes documente resident did not answ indicated the neurolo normal limits. The facility lacked do neurological checks a lacked information re refusing any further r An undated skin asse #10 documented the located on the foreher 0,5 cm.	e 46 Resident #10, dated 6/ d the resident had a re- light side of the foreher ed the nurse asked the received the area and ver the nurse. The not gical checks were with cumentation of any fu and the progress notes garding Resident #10 neurological checks. essment sheet for Res resident had a red are red and measured 0.5 Resident #10, dated for ber witnessed the res in the headboard, caus	/9/16 ed ad. ad. ad. a the e the the the the the the the the t	F 309	Δι	attalla	7-24-1	4
	5:30 p.m. (when the facility regarding the revealed no mention speech and being un measurements were regarding the resider than the 0.5 cm × 0.5 A Progress Note, da indicated the family f regarding the resider of the forehead that f	of the resident with un ateady. No further in the resident's recor tt's forehead bruising,	e Iclear d other m., ily side to the					
FORM CMS-25	37(02-99) Previous Versions Ob	solato	Event (D:0JLG11	Fa	cility ID: 1A0948	If continu	alion sheet Page 47 (88 Ic

FORM CMS-2567(02-99) Previous Versions Obsolate

Facility ID: 1A0948

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STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

No. 2042 P. 12/31

06/23/2016

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &	PRINTED: 08/05/2016 FORM APPROVED OM8 NO, 0938-0391		
TATEMENT OF DEPICIENCIES	(X1) PROVIDER/SUPPLIER/GLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
IND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING	COMPLETED

601 E POLK ST

WASHINGTON, IA 52353

STREET ADDRESS, CITY, STATE, 21P CODE

PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O SUMMARY STATEMENT OF DEFICIENCIES (X4) (D

165453

(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	 concerned because the resident had garbled speech and unsteady on his/her feel. 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 alde of the chest e. bruised areas to both knees The radiology reports dated 6/12/16 at 6:30 p.m. indicated the radiological findings most likely represented acute infarcts in the fet frontal lobe and left occipital temporal fobe (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	Mease See attached	7-24-16
PORM CMS-258	57(02-99) Pravious Versions Obsolete Event ID:0JLG1	nac	NALIN: NAAAA II QAHGUUQUDH 2	1991 - 99 - 10 91 40

B. WING

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No. 2042 P. 13/31

		(X1) PROVIDER/SUPPLIER/GLA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		165453	B. WING		06	/23/2016
	IOVIDER OR SUPPLIER	& HEALTHCARE GENTER O	66	TREET ADDRESS, CITY, STATE, ZIP CODE 01 E POLK ST VASHINGTON, IA 52353	1	
(X4) IP PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(25) Complet Date
F 309	Nursing Assistant) w she had worked the noticed Resident #10 stiff. The resident in the nebulizer and has She stated the resid she could not make saying. The resident the floor a couple of resident had bumpe not head. Staff CC a helped return the resident halped return the resident staff CC stated she resident had a "goos quarter on his/her fo thought the resident and struck it against Staff G LPN (Licens A CNA/CMA (Certific came to the room to stated she thought \$ resident's speech w she worked the night resident's speech so he/she hardly had a this was strange for worked the night shi resident's speech w She worked the night shi resident's speech w	t.m., Staff CC CNA (Certified ras inlerviewed and stated night shift on 6/8/16 and 0 leaning to the side and very ad outbursts and had taken d put it up to his/her face. ent's speech was garbled and sense of what he/she was t placed himself/herself on times and she thought the d his/her elbow possibly but stated she and a nurse sident to bed. Toward the end rd the resident in bed yelling. went in the room and the se egg" about the size of a rehead. She stated she had taken his/her nebulizer his/her head. She stated ed Practical Nurse) and Staff ad Medication Assistant) assess the resident. She haff G and Staff A knew the as garbled. Staff CC stated t entit on 6/10/16 and the beemed more garbled and ny clear speech. She stated she ft again on 6/11/16 and the as still garbled.	F 309	DEFICIENCY) Alease Dee at	tached	7.26
	Director of Nursing s Resident #10 had be bed. She stated affe	stated Staff BB CMA told her anged his/her head on the er a head injury neurologica) one until the physician stated			·	

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Aug.	5.	2016	2:47PM	A11	American	Care

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No 2042 P. 14/31

TATEMENT O	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		AFE CONSTRUCTION		<u>(), 0938-0</u> E SURVEY IPLETED
		185453	B, WING	 	Óf	8/23/2016
NAME OF P	OVIDER OR SUPPLIER	100403		STREET ADDRESS, CITY, STATE, ZIP CODE		<u>1120120 V</u>
PEARL VÀ	LLEY REHABILITATION	I & HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353	<u></u>	-
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFIGIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(XS) Comple Dati
F 309	was interviewed and Staff G LPN (license resident had a spot of Coordinator stated si been swinging and b stated neurological of done but they could so agitated and state the hospital but she done. She stated ne head injury should b minutes for 4 times, every hour for 4 times and then every shift the resident refused, notes. The MDS Co should notify the fam occurred. She state resident placed hims Staff DD CNA witnes resident slood up an	e 49 .m., the MDS Coordinator stated on 6/8/16 or 6/9/16, d practical nurse) told her the on his/her head. The MDS taff told her the resident had wanging his/her head. She thecks should have been the because the resident was ad she told the nurses to call was not sure if that was burological checks after a e performed every 15 every 30 minutes for 4 times, is, every 4 hours for 4 times, for 72 hours. She stated if it would be in the progress ordinator stated the facility may when such events ad that on 6/11/16, the self/herself on the floor and ssed this. She stated the d had no problems and that checks were within normal	F 30	ne please per attai	thed	726
	G LPN stated she w She stated the resid screaming and was medication. She sta	on 6/22/16 at 6:49 a.m., Staff orked the day shift on 6/9/16. ent had been yelling and given an anti-anxlety lied the resident had a red d but that she didn't know				
	what happened. Sh abnormal speech. S again on the day shi resident had no abn She stated that the t	e stated the resident had no Staff G stated she worked If of 6/12/16 and that the ormal speech on this shift. resident's daughter and wife d inquired about the resident's				

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: IA0946

If continuation sheet Page 50 of 98

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM APPROVED IB NO. 0938-0391
		FICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		LE CONST	(X3) date survey Completed	
		165453	B, WING				06/23/2016
NAME OF PI	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		601 E PC WASHIN	NGTON, IA 52353		
(X4) IÛ PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIËS Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefix Tag		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED YO THE APF DEFICIENCY)	ούια θε	(XS) COMPLETION DATE
F 309	had a "little raised are was "dime sized". SI the physician and cal resident. During an Interview of A CNA/CMA stated to the day shift and had "bolted" across the un threw himself/herself helped the nurse ass was laying on his/her room. She stated to a bruise but that she again. Staff A stated unwitnessed but Staff a thud. She stated to speech was "a little r On 6/21/16 at 6:04 p. Nurse) was interview worked the night shift notice any speech pr week before she had to the left when she to appointment. Staff F shift on 6/11/16 and sister head on the headbox angry" the last coupli she worked on 6/9/10 on the resident's fore the resident around r shock" by the look of the resident said head	as" on his forehead which he stated she consulted with led an ambufance for the in 6/22/16 at 1:47 p.m., Staff hat on 6/10/16 she worked heard that the resident nit to the shower room and on the floor. She stated she ess the resident as he/she right side in the shower to resident had already had thought he hit his/her head the incident was f K, CNA told her she heard in this shift the resident's	F 3	39	Mease Are attac	hed	7:36-16
FORM CM8-25	67(02-99) Previous Versions Ob	solata Event ID:0,/L	GII	Facility ID:	1A0946	f continualik	on sheet Page 51 of 96

lug.	5.	2016	2:48PM	A11	American	Care
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CENTERS FOR MEDICARE & MEDICAID SERVICES	(3) DATE SURVEY COMPLETED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X3)	
165453 B. WING	06/23/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PEARL VALLEY REHABILITATION & HEALTHGARE CENTER O 601 E POLK ST WASHINGTON, IA 52353	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (#ACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE
F 309 Continued From page 61 F 309 the bruiking to the resident banging his/her head on the bed. Stelf BB stated when she saw the resident again on 6/11/16, his/ner speech was in and out but more garbled. Staff BB stated the resident shays had some speech difficulty because he/she had clenched teeth. Pleasel During an interview on 6/22/16 at 11:56 a.m., the resident shays had some speech difficulty because he/she had clenched teeth. Pleasel During an interview on 6/22/16 at 11:56 a.m., the resident shays had come sheech difficulty various bruises. F 312 F 312 483.25(a)(3) ADL CARE PROVIDED FOR daily living receives the necessary services to maintain good nutifilen, grooming, and personal and oral hygione. F 312 This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility felled to provide the two baths or showers a week for 8 of 13 resident interviews. In facility felled to provide the two baths or showers a week for 8 of 13 resident if 4, #2, #4, #5, #11, #16, #17, #16.) The facility reported a census of 60 residents. AuthAuthee Holds Findings include: 1. The Minimum Data Set (MDS) assessment dated 41/4/16 identified Resident #16 aligncoses to holds/the Parkinson'n disease. The MDS revealed the resident with a BIMS (Brief Interview Bose	8-17-16

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0JLG11

Facility ID: 1A0948

If continuation sheet Page 52 of 98

Aug. 5. 2016 2:48PM All American Ca	Aug.	5. 2016	2:48PM	A11	American	Care
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No. 2042 P. 17/31

DEPARTI	MENT OF HEALTH AN	ND HUMAN SERVICES			FORM OMB NC): 08/05/2016 / APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL		(X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(XS) DATE COMF	SURVEY PLETED
		165453	B. WING	······		/23/2016
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O	60	REET ADDRESS, CITY, STATE, ZIP COD 1 E POLK ST ASHINGTON, IA 52353	E	
(X4) ID PREFIX TAG	(FACH DEFICIEN)	YATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X6) COMPLETION DATE
F 312	for Mental Stalus) so resident with no sho problems and no pro- dally decision makin The Care Plan dated problem of the reside Living (ADL) self-car to Parkinson's disease staff the resident read by one staff for shown necessary. Resident #1's May 2 Interventions: ADL- documentation indite provided May 16th, During an interview Resident #1 staled he/she had only read stated he/she wash room. Resident #1 morning if he/she of shower list. 2. During an interview Resident #1 reports two baths per week Upon record review Sheets and Interve and June of this ye that the resident diff week of May 22nd, not provide the Jun Upon further record lacked documental	2016 flowsheet listed under bathor, revealed work of 5/2/2016 at 12:30 p.m., since admission on 4/7/16 setud 3 showers. Resident #1 estimation on 6/21/16 at 7:08 a.m. ed he/she would like to have	F 312	please see a	tached	₹.17 IL
L	Inter comprover for t			acility (D: 1A0948	if continuation sh	eet Page 53 of

FORM CMS-2587(02-89) Previous Versions Obsolete

Event (D: 0JLG11

Facility (D: 140948

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No. 2042 P. 18/31

PRINTED:	08/05/2016
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-		ID HUMAN SERVICES					APPROVED 0.0938-0391
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		INFARTICIONTION NUMBER.		PLE CONSTRUC G	COMPLETED		
				•			
	· · · · · · · · · · · · · · · · · · ·	165453	B, WING			06/	23/2016
NAME OF PI	Rovider or Supplier			STREET ADDI 601 E POLK	RESS, CITY, STATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O			ON, JA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) ROSS-REFERENCED TO THE APPROPR DEFICIENCY)	36	(X5) Completion Date
F 312	Continued From page 29th. 3. The MDS assessm Resident #2 documen 14 out of 15 on the B cognition. The MDS of diagnoses including p diabetes mellitus, and identified the resident ulcer. The resident's Care F on 5/5/16 that the resident ulcer. The resident's Care F on 5/5/16 that the resident of one slaff member f and as necessary.	e 53 hent dated 5/5/16 for hiled the resident scored a IMS, indicaling intact revealed that the resident esistance of one person for houmented the resident had beripheral vascular disease, d chronic pain. The MDS t with an unhealed pressure	F 3		DEFICIENCY) Mease Are attach	øð	<i>₹-17-1</i> 6
	of April, three shower documentation provid	had four showers the month is the month of May, and no led for showers in the month acked documentation as to week did not happen.					
	documented Residen 15 for the BIMS India MDS revealed that th extensive assistance The MDS documente	of one person for balhing. d the resident had asthma, morbid obesity.					
		Plan identified a focus on	<u> </u>		in zr odo		Dama PA -600
FORM CMB-255	7(02-99) Frevious Versions Obs	olate Event (O; O)LG1	1	Facility ID: (A09	40 II CONUN	uauon shee	1 Page 54 of 98

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No. 2042 P. 19/31

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		ND HUMAN SERVICES MEDICAID SERVICES				M APPROVE D. 0938-039
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILD(NG		e Survey Pleted		
		165453	8, WING		06	/23/2016
	ROVIDER OR SUPPLIER	N & HEALTHCARE CENTER O	601 E	et address, city, state, zip code : Polk St Hington, 1A 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES 2Y MUSY BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 312	related to morbid ob- slaff to provide the re- twice a week with ex- staff member. Upon record review of Sheets and Interveni- and June of this year revealed the residen during that time period documentalion as to not occur. 5. The Admission Mil- for Resident#17 doc a 15 out 15 for the B cognition. The MDS required total assists bathing. The MDS di- had diagnoses include failure, and diabetes The Care Plan lackee the resident's bathing. Upon record review of Sheets and Interveni- and June of this year the resident had only time period reviewed documentalion as to not occur for the real 6. The Quarterly MD for Resident#18 doc scored a 15 out 15 for	mance deficit in self-care esity. The Care Plan directed esident with a shower or bath itensive assistance of one of the resident's Skin Shower tion Sheets for April, May, r, the documentation t only had four showers ad. The record lacked why two baths a week did DS assessment dated 5/2/16 umented the resident scored IMS, indicating intact Identified the resident ance of one staff member for boumented that the resident ding morbid obesity, heart d direction to staff related to g. of the resident's Skin Shower iton Sheets for April, May, r the documentation revealed y two showers or baths for the t, The record lacked why two baths a week did dent. S assessment dated 5/11/16 umented that the resident or the BIMS, indicating intact indicated the resident	F 312	please See atta	chad	₹-17 <i>:</i> 40

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No. 2042 P. 20/31

ENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION		e survey IPLETED
		165453	a. Wing		06	5/23/2016
AME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
EARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O	1	E POLK ST		
				SHINGTON, IA 52353		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENYIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE AGTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X6) Completic Date
F 312	Continued From page	. 55	F 312			8-17-1
	bathing. The MDS do	cumented that the resident ing a stroke, morbid obesity,				
	12/30/15 as self-care to a stroke. The Care	istance of one staff member				
	Sheets and Intervenil and June of this year that the resident only time period reviewed.	f the resident's Skin Shower on Sheets for April, May, the documentation revealed had five showers for the The record lacked why the two baths a week		Please See atte	aCh <i>ed</i>	
	A, Certified Nurse Aid 12 hours shifts, 6:00 a the residents are getti week, but the residen week. Staff A reported	is should get two baths a I baths are not getling done in't get enough staff hired or				
	U, ONA, reported that and you document the Sheets. The Shower & document the baths, a resident may have, ar nurse to sign. If a resi resident is in the hosp the Shower Skin Sheet the bath done you pas	a 6/22/16 at 10:51 a.m. Staff each hall gets a bath list, baths on Shower Skin Skin Sheets are used to any skin issues that the diften they are given to the dent refused, or if the lital you document that on st. If you are not able to get is the information onto the ck with the resident the next				

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P. 21/31 No. 2042

PRINTED: (08/05/2016
FORM A	PPROVED

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/05/2016 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER;	1				e Survey Pleted
		185453	B. WING		,	06	/23/2016
NAME OF P	ROVIDER OR SUPPLIER		.		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PEARL W	ALLEY REHABILITATION	& HEALTHCARE CENTER O		1	601 E POLK ST WASHINGTON, IA 52353		
(X4) ID PREFIX TAQ	(EACH DEFICIENC	ATEMENT OF DEFIGIENCIES Y MUSY BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefi Tag		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E	(X5) Completion Date
	 least two limes, and of During an interview of R, Registered Nurse, Skin Shaets to the nubbeen given a bath. If another staff member to see if she/he will caresident refuses a sechart a refusal of the During resident group 1:48 p.m. 4 of 6 resident group 1:48 p.m. 4 of 6 resident group 1:48 p.m. 4 of 6 resident reported that enough help. During an interview of M, CNA, reported resa week. There are hat check the schedules the CNAs fill out bath the nurses to sign. If a resident is reapproact then the nurse talks the refusals are charted to sheets and the nurse refusals. 7. The MDS assesses diagnoses for Resident sets and the nurse talks the refusals. 7. The MDS assesses diagnoses for Resident sets and the nurse talks the refusals. 7. The MDS assesses diagnoses for Resident sets and the nurse talks the refusals. 7. The MDS assesses diagnoses for Resident sets and the nurse talks the refusals. 7. The MDS assesses diagnoses for Resident sets and the nurse talks the refusals. 7. The MDS assesses diagnoses for Resident sets and the nurse talks the refusals. 7. The MDS assesses diagnoses for Resident sets and the nurse talks the refusals. 7. The MDS assesses diagnoses for Resident sets and the nurse talks the refusals. 7. The MDS assesses diagnoses for Resident sets and the nurse talks the refusals. 7. The MDS assesses diagnoses for Resident sets and the nurse talks the refusals. 7. The MDS assesses diagnoses for Resident sets and the nurse talks the refusals. 	a nurse will coach the reapproach the resident at document the reapproach. In 6/22/16 at 9:00 a.m. Staff reported the CNA give the trise after the resident had a resident refuses then 'will reapproach the resident omply with a bath, if the cond time then the CNA will bath in the CNA books. In the the the the they did or baths per week. The at the facility did not have in 6/22/16 at 9:13 a.m. Staff idents are given baths twice if books for the CNA to for the resident's baths, and sheets, and give them to a resident refuses a bath the hed three times by the CNA, o the resident. The resident by the CNA on the bath signs that, after the three nent, dated 5/12/16, listed nt #11 which included chotic disorder, and legal stated the resident required of 1 staff for bed mobility, nd bathing, limited or personal hyglene, and staff for tollet use. The		312	Please See attack		8-17-16

FORM CMS-2567(02-99) Previous Versiona Obsoleta

Event ID: 0JLG11

Facility (D: 1A0948

If continuation sheet Page 57 of 98

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No. 2042 P. 22/31

PRINTED:	08/05/2016
FORM	APPROVED

	MENT OF HEALTH AN						FORM APPROVEL OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	ICLIA (X2		CONSTRUCTION		(X3) DAYE SURVEY COMPLETED		
		165463	B. 1	WING			06/23/2016		
NAME OF PL	ROVIDER OR SUPPLIER			្សា	REET ADORESS, CITY, STATE, Z	IP CODE			
PEARLVA	LLEY REHABILITATION	& HEALTHCARE CENT	ER Ø		1 E POLK ST ASHINGTON, IA 82353			_	
(X4) ID PREFIX TAG	(EACH DEFICIENC	AYEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMA	FULL	id Prefix Tag	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD B TO THE APPROPRIA			
F 312	MDS listed the resider 15, indicating intact of The care plan for Resident re- for showering twice a The June bath sched that staff documentaria a bath on 6/7/16. The further documentation resident with bathing and 6/22/16. During an interview of Resident #11 stated shower per week and week. The resident reason he/she did not they needed more st he/she would like more especially in the sum During an interview of Director of Nursing s 2 showers per week. 8. According to the had diagnoses which non-Alzheimer's den obesity. The MDS of required extensive a member for bathing. The resident's curred ADL self-care deficit disorder and directed assistance by 1 staff and as necessary.	ent's BIMS score as 14 sognition. sident #11, revised 5/1 equired assistance of 1 a week and as necesse lule for Resident #11 s d assisting the resident e schedule lacked any n of staff assisting the during the period of 6 on 6/22/16 at 8:00 p.m he/she was fucky to he d rarely had 2 showers stated staff told him/he of get showers was be aff. The resident state ore than 1 shower peri- imer. on 6/22/16 at 5:08 p.m tated residents should 3/10/16 MDS Resident h included diabetes mo- nentia, seizure disorded locumented Resident is ssistance of one staff	10/16, I staff ary. showed at with / /1/16 ., ave 1 3 per er the cause ed week, ., the I have t #4 ellitus, er and #4 an iental halve veek	F 312	Please				
FORM CMS-20	67(02-99) Previous Versions Ol	bsolele	Event ID: 0JLG11	Fa	cility ID: IA0948	If contin	welion sheel Page 58 of	90	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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No. 2042 P. 23/31

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

		MEDICAID SERVICES				<u>//B NO. 0938-0</u>
	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A, BUILDING	DNSTRUCTION	(XC	3) DATE SURVEY COMPLETED
		165453	B. WING			06/23/2016
NAME OF P	ROV/DER OR SUPPLIER	- -	STRE	ET ADORESS, CITY, STATE, ZIP CO	2002	000000000
		A HEALTHCARE CENTER O	601 8	E POLK ST		
			WAS	SHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES 37 MUSY BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefix Yag	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	on Should Be Heappropriate	(X5) COMPLET DATE
F 312	Continued From pag bath/shower only 6 tf specified 9 times in M bath/shower 4 out of Record review revea bath/shower 3 times specified 7 times thu refused a bath/shower 9. The 5/3/16 MDS 6 with diagnoses which malnutrition and histo totally dependent on extensive assistance The resident's durren provide bathing/show extensive assistance Record review reveal bath/shower only 4 tf specified 9 times in M bath/shower only 2 tf specified 7 times thus received a bath/show thus far in June. During an interview o Director of Nürsing re showers that need to nurse's station. The r assignments and the complete the shower bath/shower book that station. Interview on 6/22/16 is Development Coordin CNA task sheets for the how to care for the re	e 58 Imes in May instead of the May. Resident #4 refused a the 6 times offered. led Resident #4 offered a in June instead of the s far in June. Resident #4 er 2 out of 3 times offered, documented Resident #5 in included seizure disorder, ory of heart malformation and bathing assistance with the of one staff member. tt Care Plan directed staff to vering two times a week with	F 312		0	<i>7.17</i>
	Coordinator went to s	how the task sheets in Hall				
	I DULTHERE WERE NO S	heets. On Hall 2 found only	1 1			1

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No. 2042 P. 24/31

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/05/20 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	e construction	(XS) DATE SURVEY COMPLETED
		165453	B. WING		06/23/2016
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E POLK ST WASHINGTON, IA 52353	
(X4) ID PREFIX 7AG	(EACH DEFICIENO	ATRMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC
F 312	should consist of she and 300 rooms. Hall :	dents, Hall 1 task sheets ets for residents in 100, 200,	F 312	Please see att	ached 8-17-1
	483.25(h) FREE OF A HAZARDS/SUPERVI		F 323		7:26-1
	as is possible; and ea	as free of accident hazards		Ola al l	
	by: Based on observation interviews, the facility nursing supervision to ensure a resident's en- of accident hazards a revise the Care Plan the planned alarms of of 5 residents reviewed	is not met as evidenced n, record review and staff falled to provide adequate prevent accidents and nvironment remained as free s possible and falled to with interventions to ensure build be heard by staff for 1 ad with a recent fall history hellity reported a census of		please see attou	thed
	Assessment with a re to a significant chang				

FORM CMS-2667(02-99) Provious Versiona Obsolata

Event ID: 0.1.G11

Facility (D: 1A0948

If continuation sheet Page 60 of 98

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No. 2042 P. 25/31

PRINTED: 08/05/2016
FORM APPROVED
OND NO 2020 0204

	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	·····	te Survey Mpleted
		165453	B. WING	<u> </u>	0	6/23/2016
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	É	
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353		
(X4) ID PREFIX YAQ	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUSY BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	iD PREFIX TAG	PROVIDER'S FLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X6) COMPLETIO DATE
F 323	severe cognitive imp delirium, and require or more staff membe bed and chair, bathin personal hygiene. The resident had daily be others. A MDS Assessment of 5/20/16 indicated the extensive assistance for transfers to and fill dressing, toileting and identified the resident behaviors that were of daily behaviors not d The resident's nursin problem identified as (ADL) self-care defice resident to maintain of and interventions that 1. Assist of 1 to 2 for 2. Floor alarm with pr 5/28/16. 3. Sling to left arm at 4. Extensive assistance initiated 12/30/15. 5. Limited assistance initiated 2/28/16. 6. Supervision/assist initiated 2/28/16. 7. Limited assistance hygiene and oral care 8. Limited assistance revised on 2/28/16. Another Care Plan pr	airment with symptoms of d extensive assistance of 2 ra for transfers to and from ag, dressing, tolleting and he MDS indicated the haviors not directed at with a reference date of resident required continued by 2 or more staff members rom bed and chair, bathing, d personal. The MDS it displayed daily verbal directed at others and other irected at others. g Care Plan Included a callvilles of daily living it, with 8/3/16 goal for the current level of ADL function, it included: transfers, initiated 5/6/16. ad for safety, initiated all times, initiated 6/20/16. here by 1 staff for showers, of 1 staff for dressing, ance of 1 staff for personal e, initiated 2/28/16. of 1 staff for toilel use,	F 32	3 Please See att	ached	7-26-14
		lated to an unsteady galt,	[

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No. 2042 P. 26/31

PRINTED: 08/05/2016
FORM APPROVED
AND NA 0029 0201

		ND HUMAN SERVICES			FOR	D: 08/05/201 M APPROVE <u>D. 0938</u> -039
TATEMENT	ÓF DEFICIENCIES F CORRECTIÓN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A, BUILDING	NOITDUÁTENC	(X3) DATI	e survey Pleteo
		165453	ß. WING		06	/23/2016
NAME OF P	ROVIDER OR SUPPLIER		818	EET AODRESS, CITY, STATE, ZIP CODE	00	12312010
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O		e polk st Bhington, IA 52353		
(X4) (D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE AGTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	10 66	(X5) COMPLETION DATE
F 323	resident's broken arm complication, and inte 1. Floor mat alarm by 2. Hi-Lo bed In place, 3. Physical therapy of mobility, initiated 6/17 Another Care Plan pr with dementia, with 8, would be able to com daily basis, and interv 1. Cue, reorient and e initiated 2/28/16. 2. Keep the resident's to provide consistent possible, initiated 2/20 3. Ask yes/no questio resident's needs, initia 4. Present just one th command at a time, in The resident's record The incident/Accident 5/30/16 at 1:45 p.m., the floor beside the bu The report indicated the disoriented as was pri- were identified and th The Incident/Accident 5/31/18 at 1:00 p.m., on the floor on back in when the nurse attern The report indicated the facility sent the re- resident had a diagno	Ih 8/9/16 goal that the would heal without arvenilons that included: bed, initiated 6/1/16. initiated 6/1/16. initiated 6/1/16. consults for strength and 7/16. oblem Identified the resident /9/16 goal that the resident municate basic needs on a ventions that included: topervise as needed, a routine consistent and try care givers as much as 8/16. ns in order to determine the ated 2/28/16. ought, idea, question or nitiated 2/28/16. Indicated the following: t Report form identified on staff found the resident on ad and lying on left side, he resident as confused and for to the fall. No Injuries e fall was unwitnessed. t Report form indicated on the staff found the resident noom. The resident yelled pted to assess the left arm. he fall as unwitnessed and aldent to the hospital. The sed of a fractured left boone) and returned to the	F 323	Please See attack	had	726-10

FORM CMS-2587(02-99) Previous Versions Obsolete

Facility ID: 1A0948

If continuation sheet Page 62 of 98

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED:	08/05/2016
FØRM	APPROVED
OUD NO	2000 000V

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u>O. 0938-0391</u>
	ôf defic)encies F Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRU			e Survey Pleted
		165453	B. WING			06	/23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADD	DRESS, CITY, STATE, ZIP CODE		
PEARL V	LLEY REHABILITATION	& HEALTHGARE GENTER O		601 E POLK WASHING	CST TON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSO IDENYIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED YO THE APPRO DEFICIENCY)	D BE	(X6) Completion Date
F 323	Continued From page	ə 62	F:	323			7:26-16
	Observations of the n following:	esident idenlified the					
	back in bed with door	o.m., the resident laid on open and made repeated and to get up". The yells Int rooms away from			۵	·	
	room was closed and a.m. when a certified	m., the door to the resident's remained closed at 6:08 nursing assistant (CNA) n the room with the resident.			fleasi See atta	Ched	
	the resident at a dinin residents that had foo #7 asked the resident	m., the staff person placed g room table with 2 other d and beverages. Resident s for their juice and then ing to drink" several times.			•		
	the dining room after i and made repeated ye and "my arm hurts, i r	nm., the resident seated in the meal was completed ells "help me, i'm afraid", need to go to the doctor". to the resident's yells but a					
	neighboring resident of was broken and altern The resident then had	explained the resident's arm apted to calm the resident. I repeated unanswered yells ve got to go to the doctor".					
		n., the door to the resident's observation identified no om with the resident.					
	Interviewed and stated hall of Resident#7 ' s i	.m., Staff K, CNA, was I her assignment was the room on 5/31/16 day shift. not put the resident in bed					
ORM CMS-256	(02-99) Previous Vereions Obso	Nele Event (D:0JLG1)		Facility ID: 1A09	H8 If con	linuation shee	(Page 63 of 98

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No. 2042 P. 28/31

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 08/05/2016 M APPROVED O. 0938-0391
	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(XS) DATI	e Survey Pleted
		165453	B. WING		06	/23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUSY BE PRECEDED BY FULL SC IDENTIFYING INFORMATION))o PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO ĐE	(X5) COMPLETION DATE
	after lunch and did no resident's door was of could hear the bed ak the resident yelled for resident's room after I opened the door and floor, on back and blo she stayed with the resident's staff K stated the real frequently. Staff K sta didn 't like to hear it a Staff K stated she had repeated occasions the resident's door becaus resident's door becaus resident's door becaus resident's alarms or ca Staff K stated she had repeated occasions the resident's door becaus resident's door. Staff by Staff G, licensed pr position the resident o wall) in order to decreas hallway. Staff Q state (CNA's that they should door as likey could not help. On 6/22/16 at 5:40 p.m practical nurse) and un resident's door was off	t know who did. The osed and she stated she arm going off [activated] as help in the hallway near the unch. Staff K stated she found the resident on the od on arm. Staff K stated isident and yelled for help. dent called out or yelled the the residents and staff ind shut Resident #7's door. I instructed staff on ley should not shut the se they could not hear the alls for help when needed. dent didn't use [activate] the an., Staff Q, CNA, was i she worked the evening is hall on 5/30/16 and d the resident had dn't know what they were The staff and residents, room across the hall, didn't it's yells and closed the Q stated she was instructed actical nurse (LPN), to in his/her left side (faced the ase the noise audible in the d she instructed other i not shut the resident's hear the resident's calls for h., Staff H, LPN (licensed alt manager, stated the en closed without staff in ad she had instructed the	F 323	please see attai		7:26.16

Aug, 5	. 201	6 7	2:50PM	All	American	Care
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No. 2042 P. 29/31

		D HUMAN SERVICES				PRINTED: 08/05/20 FORM APPROVE OMB NO: 0938-035
TATEMENY	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		165453	B. WING			06/23/2016
	NOVIDER OR SUPPLIER	& HEALTHCARE CENTER O	6	TREET ADORESS, CIT 101 E POLK ST NASHINGTON, IA		
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of Deficiencies Y Must be preceded by full .sc (Dentifying (NFORMATION)	ID PREFIX TAG	(EACH CC	DER'S PLAN OF CORRECTIO DRRECTIVE ACTION SHOULD ERENCED TO THE APPROP DEFICIENCY)	DE COMPLETION
F 323	staff continued to leave alone with the door of On 6/22/16 at 7:35 p. worked the 6:00 p.m., found the resident's of the room, she opened staff to leave the door in order to hear the al- help, and was an ong residents that lived in yelled at night and of Staff J stated the resi- light. On 6/22/16 at 5:55 a. interviewed and state night shift for over 3 y resident always called check on the resident often attempted to ge stated after she/he br needed at least 1 sta- stand. On 6/23/16 at 10:25 a nurse stated she word 5/31/16 and responded MDS nurse stated the	ose the resident's door and ve the resident in the room osed after instructed not to. m., Staff J, LPN, stated she to 6:00 a.m. shift, often loor closed without staff in i the door and instructed ropen at least a few inches arms and resident's calls for	F 323		se attoiche	7- <i>346</i> -16
F 329 SS=G	floor. The bed alarm been silenced. The M was in the room with which CNA).	was audible and hadn't IDS nurse slated Staff H a CNA (didn ' t remember IMEN IS FREE FROM	F 329	Please .	We attache	ed 7-26-1

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No. 2042 P. 30/31

	of Deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		e survey Ipleteo
		166453	8. WING	· · · ·		100 (044 8
NAME OF P	Rovider or Supplier			STREET ADDRESS, CITY, STATE, ZIP CO		23/2016
PEARL W	ALLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	ID PREFI) TAG		IN SHOULD BE	(XS) COMPLETIO DATE
F 329	unnecessary drugs. <i>A</i> drug when used in sx duplicate therapy); or without adequate mod indications for its use; adverse consequence should be reduced or combinations of the re Based on a comprehe resident, the facility m who have not used ar given these drugs uni therapy is necessary i as diagnosed and doo record; and residents drugs receive gradual behavioral intervention contraindicated, in an drugs.	regimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or altoring; or without adequate or in the presence of es which indicate the dose discontinued; or any easons above. Ansive assessment of a ust ensure that residents allpsychotic drugs are not eas antipsychotic drug to treat a specific condition sumented in the clinical who use antipsychotic dose reductions, and ns, unless clinically effort to discontinue these	F3	Alease Del a	ttaChed	7-26-1
	by: Based on record revia facility failed to ensure for nonpharmacologic administration of an ar (Resident #B) and faile (Sinemet) as ordered i	Is not met as evidenced aw and staff interview, the residents were monitored al interventions prior to the nti-anxiety medication ed to administer medication by the physician (Resident isted of 27 residents and				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:0JLO11

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Facility ID: 1A0948

It continuation sheet Page 66 of 98

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Aug.	5	2016	2:50PM	A11	American	Care
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No. 2042 P. 31/31

		ND HUMAN SERVICES MEDICAID SERVICES			FO	ED: 08/05/2016 RM APPROVED VO: 0938-0391	
STATEMENT	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		165453	D. WING		a	6/23/2016	
	ROVIDER OR SUPPLIER	I & HEALTHCARE CENTER O		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E POLK ST WASHINGTON, IA 52353			
(X4) (D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CRO33-REFERENCED YO YHE API DEFICIENCY)	OULD BE	(X5) COX/PLE);CN DAYE	
F 329	 Resident #1 had a assessment with a re The MDS Identified F including heart failure disease, renal insulfi hyperlipidemia, non-/ Parkinson's disease, asthma. The MDS in BIMs (Brief Interview 15 of 15. A score of long term memory pr with cognilive skills fai identified the residem one staff member for roorn, and dressing, resident to be indepe on and off the unit, fai hygiene. The Care Plan dated problem of high risk fai and seizure disorde interventions include administer medicatio document for effective The Progress Notes indicated at 5:26 p.m a phone call from the stating they have Re- possibly having a sel Resident 's #1 room on the floor between stand, head under th stomach. Staff G mot the resident and place 	MDS (Minimum Data Set) iference date of 4/14/16. Resident #1 with diagnoses o, gastroesophageal reliux ciency, diabetes mellilus, Alzheimer's demenità, seizure disorder, and dicated the resident had a for Mental Status) score of 15 represented no short or oblems and no problems or daily decision. The MDS t required limited assist of bed mobility, ambulation in The MDS determined the endent with transfers, location ollet use and personal 5/2/2016 included a for falls related to Parkínson ' ar. The Care Plan d and directed staff to ns as ordered, monitor and eness and side effects, dated 5/2/16 at 6:57 p.m. n . the nurse, Staff G, received i hospital on-call nurse sident #1 on the phone with zure. Staff G entered and the resident found lying the wheelohair and bedside e bed and positioned on ved all objects surrounding	F 3	Please Dee atta	Ched	7-26-11	

FORM CMS-2567(02-98) Previous Versions Obsolete

Event ID; MLG11

Facility ID: (A0948

If continuation sheet Page 67 of 98

	of Deficiencies F Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1 · ·	LE CONSTRUCTION		O. 0938-03 E SURVEY IPLETED
		165453	B. WING		0	3/23/2016
NAME OF P	RÖVIDER ÖR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		SYREET ADDRESS, CITY, STATE, ZIP COD 601 E POLK ST		
PEARL V	ALLEY REHABILITATIO	N & HEALTHCARE CENTER O		WASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL A LEC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) Conflete Date
F 329	call to the resident ' order to send the re- for further evaluation at 5:58 p.m. via amb leaving the facility. On 5/13/16 at 12:30 Interviewed and stat not receive the sche medication. Resider until 4 p.m. and the the 2 p.m. medication Resident #1 stated f went to get his/her S EE, Certified Medica stated at 5 p.m. Staf dose and the 6 p.m. Resident #1 stated f taking the medication the medication at on so". Resident #1 stated f taking the medication the medication at on so". Resident #1 stated f with the nurse if it we double dose. Reside in bed and about a h the room spun. The not see and had the Resident #1 stated f to a wheelchair and stated he/she then c nurse and got on the 25 minutes; the on-c while he/she remain facility nurse came in	s physician and received an sident to the emergency room n. The resident left the facility pulance continued to seize as p.m. Resident #1 was ad on 5/2/2016, he/she did duled 2 p.m. Sinemet at #1 stated when he/she slept staff dld not wake him/her for on administration of Sinemet. te/she woke up at 4 p.m. and Sinmet medication from Staff ation Aide (CMA), Resident #1 if EE administered the 2 p.m. dose at the same time. he/she asked Staff EE before in if it would be safe to take all ce and Staff EE said "I think ated he/she took the a double dose of Sinmet. Staff EE never even checked build be alright to take a ent #1 stated he/she feit like resident stated he/she feit like resident stated he/she, could call light on for 15 minutes. he/she allempted to transfer feil to the floor. Resident #1 alled the on-call hospital e phone with that nurse about call nurse phoned the facility ed on the phone, and the not his/her room then and out at that time. Resident #1	F 32	please see at	Fached	7:26:1

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	Aug.	5.	2016	2:52PM	All	American	Care
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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No. 2043 P. 2/14

PRINTED:	08/05/2016
FORM	Approved

	S FUR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		E CONSTRUCTION	(X8) DATE SURVEY COMPLETED	
		165453	B. WING			06/23/2016	
NAME OF P	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				6	301 E POLK SY		
		& HEALTHCARE CENTER O		V	NASHINGTON, IA 52353		
(X4) (d Prefix Tag	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefi Tag		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X6) COMPLETION DATE
F 329	Conlinued From page life support in the inte hospital. Resident #1 conlinuous selzure ad Sinemet affected his/i stated he/she reporte- of Nursing) and the D up [discipline] Staff El dose of Sinemet, Review of the Dischar indicated Resident #1 and discharged on 5/6 diagnoses included: e diagnoses: morbid ob arteriovenous malform s disease, obstructive methicillin resistant sta (MRSA) pneumonia, o spinal stenosis (narrow On arrival the resident Resident able to be e) Resident discharged o nursing facility. On 5/19/16 at 4:15 p.r (DON) was interviewe reported to her on 5/6 administration. The D0 a chance to investigate stated the resident had hospital when he/she i DON stated the resident time of reporting this.	a 68 nsive care unit of the stated he/she had divity and the double dose of her heart. Resident #1 d this to the DON (Director ON said he would be writing for administrating a double rge Summary dated 5/5/16 was admitted on 5/2/16 5/16. Resident #1 principal pilepsy with other pertinent esity, cerebral nation, seizure, Parkinson ' pulmonary disease, aphylococcus aureus earebral aneurysm, jumbar wing of lumbar vertebrae), t intubated and sedated, dubated the next day. on 5/5/16 back to skilled n. the Director of Nursing d and stated Resident #1 16 about medicalion DN stated she had not had a he issues. The DON I just returned from the reported concerns, The nt was to confused at the The DON further stated bie up on a missed dose of		329	DEFICIENCY)		726-16
	then staff are to fill out monitor the resident, n						I
		nd document in the nurse '					

FORM CMS-2567 (02-99) Previous Versiona Obsolate

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Even1 ID: 0.4LG11

Facility ID: 1A0948

If continuation sheet Page 69 of 98

	۸	5 0016 0-50P	M All American Care			No. 2043	P. 3,	/14
DEF	PARTN	IENT OF HEALTH AN	ID HUMAN SERVICES				FORM); 08/05/2016 APPROVED): 0938-039 <u>1</u>
STATE	MENT Ö	S FOR MEDICARE & F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	1 V. 1		CONSTRUCTION	(X3) DATE COMP	survey Leted
			165453	B. WING		·	06/	23/2016
1		NOVIDER OR SUPPLIER	& HEALTHCARE CENTER O		61	TREET ADDRESS, CITY, STATE, ZIP CODE D1 E POLK ST VASHINGTON, IA 52353		
PR	4) ID Refix rag	(EACH DEFICIENC	atement of deficiencies Y must be preceded by full LSC identifying information)	id PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE AGTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) Completion Date
5	7 329	s notes. The DON sta report was completed On 5/20/16 at 2:11 p. Medication Alde) was 5/2/16 she worked of 5:00 p.m. when aske Staff EE stated Resid said he/she never re- medication. Staff EE by her and said "on s 2 p.m. dose. Staff EE Immediately gave the Sinemet and she sig	ated no medication error d for Resident #1. .m., Staff EE, CMA (Certified as Interviewed and stated on in the floor [giving cares] until id to administer medications. dent #1 came up to her and ceived their 2 p.m. Sinemet stated Staff G, nurse, stood shoot " and Staff G gave the	F	329	Aleasi Der atta		7#16-16

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

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FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 0/I.G11

Facility ID: IA0946

Aug.	5.	2016	2:52PM	A11	American	Care
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No.	2043	Ρ.	4/14

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	PRINT	ΈÖ:	0	8/05/2016
	FO	RM.	ΑF	PROVED
	OMBI	NO.	0	938-0391

DEPARTMENT OF HEALTH	AND HUMAN SERVICES			FORM APPROVED OMB NO, 0938-0391
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SLIPPLIER/GLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	B. WING		06/23/2016
NAME OF PROVIDER OR SUPPLIER PEARL VALLEY REHABILITATI	ON & HEALTHGARE CENTER O		STREET ADDRESS, CITY, STATE, ZIP CODE 801 E POLK SY WASHINGTON, IA 52353	
(EACH DEFICIE	Statement of Deficiencies NCY Must be preceded by full SR LSC Identifying Information)	IÓ PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
resident, notify the family and docume never asked her a 's Sinemet nor did doubling up on the dose of Sinemet. 3 phone call at 5:26 nurse regarding th she went to the re and resident on th stated she assess resident is physic resident to the em evaluation, and re transferred via an looked at the resile resident had calle 5:06 p.m. On 5/25/16 at 3:3 Interviewed and a side effects and p can build up a tol would be difficult Sinemet to the re Review of Reside Indication a medi EE notified facility back, 2 p.m. and resident being m Sinemet, and tha notified of It.	cation error form, assess the resident 's physician and ant it. Staff G stated Staff EE bout administering the resident it Staff EE report anything about o resident 's 2 p.m. and 6 p.m. Staff G stated she received a p.m. from the hospital on-call be resident and Staff G stated sident 's room, no call light on, e floor having a seizure. Staff G ed the resident and called the ian and order received to send lergency room for further sident was immediately bulance. Staff G stated she dent 's phone and noted the d the on-call nurse at 5:04 or 0 p.m., the Pharmacist was tated Sinemet has a long list of eople who take this medication erance. The Pharmacist stated it to relate the double dose of	F 32	Please Dec attache	7:26-16

		ND HUMAN SERVICES MEDICAID SERVICES			OMB N	M APPROVE 0. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
		165453	B. WING		06	5/23/2016	
NAME OF P	ROVIDER OR SUPPLIER		- ST	REET ADDRESS, CITY, STATE, ZIP CODE			
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O		1 E POLK ST ASHINGTON, 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 COF {EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY}	Should be	IOULD BE COMPLETION	
F 329	MDS stated the reside of 1-2 staff for bed m dressing, eating, tolk bathing. The MDS in continuous disorgani and stated the reside on things and was st day of the MDS revie indicated the residen symptoms directed to verbal behavioral syi others 4-6 days out of the resident's cogniti The June Physician's #8 displayed the folk a. Haloperidol(an an mg(milligrams/mi(mill IM(intramuscularly) of for acute agliation b. Lorazepam(an an Take 1 tablet every 6 Resident #6's Medic (MAR) for May 2016 administered the pm the period of 5/10/16 documentation of the resident #8's Medic (MAR) for April 2016 administered the pm the period of 4/26/16 documentation of inti- to the administration The Care Plan for Re	ient required the assistance pobility, transfers, walking, at use, personal hygiene, and ideated the resident had ized thinking and inattention on thad trouble concentrating nort-tempered nearly every aw period. The MDS it had physical behavioral oward others daily and had mptoms directed toward of the week. The MDS listed on as severely impaired. is Order Sheet for Resident owing orders: attipsychotic medication) 5 illiter) and to Inject 0.2 ml avery 1 hour prn(as needed) attianxiety medication) 1 mg is hours prn for anxiety sation Administration Records -June 2016 identified staff Haloperidol 10 times during i- 6/18/16. The facility lacked arventions implemented prior he medication. cation Administration Records -June 2016 revealed staff Lorazepam 54 times during i- 6/12/16. The facility lacked erventions implemented prior	F 329	Please See att	ached	7:26-14	
	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING			e Survey Pleted	
--------------------------	---	--	--	---	-----------------------------------	----------------------------	--
		165453	B. WING			/23/2016	
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O	STREET ADDRESS, CITY, STATE, 21P CODE 601 E POLK ST WASHINGTON, IA 52353				
(X4) IÐ PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 329 F 334 SS=D	he/she "won't settle". staff to: Intervene bef guide the resident aw distress, engage cain the resident's respons away cainly and app During an interview o MDS Coordinator sta- non-pharmacological resident's behavior st prior to administering 483.25(n) INFLUENZ IMMUNIZATIONS The facility must deve that ensure that (I) Before offering the each resident, or the representative receive benefits and potential immunization; (ii) Each resident is o immunization Octobe annually, unless the i contraindicated or the immunized during this (iii) The resident or the representative has the immunization; and (iv) The resident's me documentation that in following: (A) That the resident	The Care Plan directed ore agilation escalated, ay from the source of aly in conversation, and, if se was aggressive, walk roach later. In 6/22/16 at 5:55 p.m., the ted nurses should document interventions on the reet or in the progress notes anti-anxiety medications. A AND PNEUMOCOCCAL alop policies and procedures influenza immunization, resident's legal as education regarding the side effects of the fered an influenza r 1 through March 31 mmunization is medically resident has already been at the period; e resident's legal a opportunity to refuse dicat record includes dicates, at a minimum, the t or resident's legal ovided education regarding nial side effects of influenza	F 329	Please Dee att Please See c		7:76-16	
ORM CMS-256)7(02-99) Previous Versions Obs		G11 Fedlity	id: 140848	If continuation she	et Page 73 of 96	
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	of Deficiencies Correction	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		E CONSTRUCTION		OMB NO. 0938 (X3) DATE SURVEY COMPLETED
		165453	B. WING			06/23/201
	ROVIDER OR SUPPLIER ALLEY REHABILITATIO)N & HEALTHCARE CENTER O	、 ·	STREET AODRESS, CITY, STAT 601 E POLK ST WASHINGTON, IA 52353	TE, ZI₽ CODE	
(X4) ID PREFIX TAG	(EACH DEFIC)E	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAGH CORRECT CROSS-REFERENCE	LAN OF CORRECTION IVE ACTION SHOULD E ED TO THE APPROPRI FIGIENCY)	IE COMPL
F 334	influenza immuniza influenza immuniza contraindications of The facility must de that ensure that — (i) Before offering to immunization, each legal representative the benefits and po immunization; (ii) Each resident is immunization, unler medically contraind already been immu (iii) The resident or representative has immunization; and (iv) The resident or representative has immunization; and (iv) The resident's r documentation that following: (A) That the reside representative was the benefits and po pheumococcal imm (B) That the reside pneumococcal imm the pneumococcal in (v) As an alternative and practilioner rec pneumococcal imm	lion or did not receive the lion due to medical refusal. velop policies and procedures resident, or the resident's receives education regarding tential side effects of the offered a pneumococcal as the immunization is icated or the resident has nized; the resident's legal the opportunity to refuse nedical record includes indicated, at a minimum, the ent or resident's legal provided education regarding tential side effects of unization; and ent ellher received the unization or did not receive mmunization due to medical refusal. b, based on an assessment ommendation, a second unization may be given after 5	F 334		e attach	8-11 2d
	years following the Immunization, unles	Trat pneumococcal is medically contraindicated or esident's legal representative				

Aug.	5. 2016 2:53	M All American Care	;		No. 2043	P. {	3/14
		D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/05/2016 M APPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ASTRUCTION	(X3) DAYE	: Survey Pleted
		165453	B. WING			06	/23/2016
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
FEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER Ö			POLK ST HINGTON, IA 52353		
(X4) ID PREFIX YAG	(EACH DEFICIENC	Atement of deficiencies Y Must be preceded by full .sc identifying information)	ið Prefix Tag		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(75) Completion Date
F 334	Continued From page	74	F 3:	34			8.17.16
	by: Based on record rewl facility failed to admin vaccines to 3 of 9 res immunization status(f failed to administer th zoster) as ordered by (Resident #6), and fai tuberculosis skin test admission for Resider census of 60 resident Findings include: 1. The Minimum Data dated 5/6/16 revealed that included non-Alz severe cognitive impa delirium, required ext more staff members f or chair, bathing, toile hygiene, and supervis required for eating, an directed at others. A physician order data	idents reviewed for Resident's #1, #6 and #7), e Shingles vaccine (herpes the physician for 1 resident led to administer a as required upon facility int #7. The facility reported a s. Set (MDS) assessment I Resident #6 had diagnoses helmer's demenila, had hirment with symptoms of ensive assistance by 2 or for transfers to and from bed ting, dressing and personal sion with set-up assistance and daily verbal behaviors ed 12/31/15 directed staff: accine has been given. (pneumococcal vaccine) is later.			Please Are attach	<u>e</u> d	

During an Interview on 6/22/16 at 3:40 p.m., the

FORM CMS-2567(02-99) Previous Versions Obsolete

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Event ID: 0JLG11

Facility ID: 1A0948

If continuation sheat Page 75 of 98

Aug. 5. 2016 2:53PM All American	Aug.	5. 2016	2 53PM	ALI	American	Care
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No. 2043 P. 9/14

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES	(X2) MULTIPLE C	ONISTRUCTION	FO OMB 1	ED: 08/05/2018 RM APPROVED NO. 0938-0391 TE SURVEY
	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,			MPLETED
		165453	B. WING			6/23/2016
	ROVIDER OR SUPPLIER	I & HEALTHCARE CENTER O	601	REET ADDRESS, CITY, STATE, ZIP CODE E POLK ST SKINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 334	MDS coordinator nur not received either va recently obtained a v responsible party ove the Shingles vaccine a copy of the Shingle provided to the resid The Shingles vaccine Chicken Pox virus an transmission of the v that are prepared fro pose a risk for transm	se stated Resident #6 had accine, and the facility had erbal consent from the er the phone to administer . The facility failed to provide as vaccination information ent's responsible party. It is prepared from the live ad poses a threat for irus (unlike most vaccines m killed viruses and do not nission of the litness).	F 334	Please See atto	iched	8-17-16
	admitted to the facilit care hospital, had dia anemia, hypertension non-Alzheimer's den severe cognitive imp delirium, and require or more staff member bed and chair, bathin personal hygiene, th the pneumococcal va offered at the facility. The initial hospital tra admission orders da administer the influe vaccines. Resident #7's record of the tuberculin skin related to pneumoco	10/16 revealed Resident #7 y on 11/19/15 from an acute agnoses that included in (high blood pressure), inentia and hip fracture, airment with symptoms of d extensive assistance of 2 rs for transfers to and from ing, dressing, toileting and e resident had not received accine and the vaccine not accine and the vaccine not accine and the vaccine not accine and the vaccine not accine and preumococcal d did not reveal administration i test or documentation ccal vaccine administration. d the influenza vaccine prior				

FORM CMS-2567(02-89) Previous Versions Obsolute

Facility ID; 140948

If continuation sheet Page 76 of 98

Aug. 5. 2016 2:54PM All American Care

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No.2043 P. 10/14

PRINTED: 08/05/2016
FORM APPROVED

	MENT OF HEALTH AN							APPROVED 0938-0391
CENTER	S F <u>OR MEDICARE & </u>							
	of Deficiencies Correction	(XI) PROVIDER/SUPPLIER IDENTIFICATION NUM		• •	CONSTRUCTION		(X3) DATE 6 COMPL	
		165453		B. WING			06/2	3/2016
NAME OF PR	KOVIDER OR SUPPLIER			8	REET ADDRESS, CITY, STATE	, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE GENT	er o		M E POLK ST ASHINGTON, IA 52353			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Atement of Deficiencies by Must be preceded by F lsc identifying informa	ULL	IĎ PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD 8 ID TO THE APPROPRU ICIENCY)	e Vte	(X5) COMPLETION DATE
F 334	Continued From page	e 7ô		F 334	,			8-17-16
	2013, directed staff: 1. All residents will be preventing infectious is medically contrained already been vacchag 2. Prior to receiving v legal representative v and education regard potential side effects 3. Provision of such of documented in the ref 4. All new residents a vacchation status up 5. Certain vacches, a pneumococcal vacch the physician-approv orders) after assessed medical contraindica	vaccinations, the reside will be provided inform ding the benefits and of the vaccinations. education shall be esident's record. shall be assessed for of on admission. such as influenza and nes may be administered facility protocol (stated ad by the physician for lions.	t aid in vaccine has ent or ation current red par anding		fleast Sel i	α ttache	d	
	2013, directed staff: 1. All residents will b vaccine. 2. Prior to or upon ac assessed for eligibilit when indicated, will I thirty days of admiss medically contraindic	ccine policy, revised A e offered the pneumod dmission, residents wil by to receive the vaccine be offered the vaccine ion to the facility unles cated. neumococcal vaccinat	coccal I bə nə, and within sş					
	status will be conduc admission. 4. Before receiving the the resident or legal information and educ and potential side eff During an interview of	oted within 5 working d he pneumococcal vaca representative shall re cation regarding the ba fects of the vaccine. on 6/22/16 at 11:18 a.	lays of cino, icelve enefits					
FORM CM8-25	67(02-99) Previous Versions Ob	osolate	Event ID:0JLG11	Fa	clity ID: 1A0948	lf contin	uation sheel	LPage 77 of 98

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 68852018 CENTERS FOR MEDICADE & MEDICAD SERVICES Opa MUTYLE CONSTITUTION MAR DUANT OF CORRECTION In PROVIDENT OF BUICKTON MURRER NEED FORMULE OF CORRECTION In PROVIDENT OF BUICKTON MURRER NEED FORMULE OF CORRECTION In PROVIDENT OF BUICKTON MURRER PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O STRET ADDRESS OF CORRECTIVE ATTIN STREET OF DEFICIENCESS PRER VALLEY REHABILITATION & HEALTHCARE CENTER O STRET ADDRESS OF CORRECTIVE ATTIN STREET OF CORRECTIONS PRER VALLEY REHABILITATION & HEALTHCARE CENTER O STRET ADDRESS OF CORRECTIVE ATTIN STREET OF CORRECTIONS PRER VALLEY REHABILITATION & HEALTHCARE CENTER O STRET ADDRESS OF CORRECTIVE ATTIN STREET OF CORRECTIONS PRER VALLEY REHABILITATION & HEALTHCARE CENTER O STRET ADDRESS OF CORRECTIVE ATTIN STREET OF CORRECTIONS PRER VALLEY REHABILITATION & HEALTHCARE CENTER O STRET ADDRESS OF CORRECTIVE ATTIN STREET OF CORRECTIONS PRER VALLEY REHABILITATION & HEALTHCARE CENTER O STRET ADDRESS OF CORRECTIVE ATTIN STREET OF CORRECTIVE ATTIN STREET OF CORRECTIONS PRER VALLEY REHABILITATION & HEALTHCARE CENTER O STRET ADDRESS OF CORRECTIVE ATTIN STREET ADDRESS OF CORRECTIVE ATTIN STREET OF CORRECTIVE A	Aug	. 5. 2016 2:54	M All American Care				No. 2043		
Mathematic of descalations (b): (c)::::::::::::::::::::::::::::::::::::	DEPART	MENT OF HEALTH AN	D HUMAN SERVICES				ł		
AND PLAN OF CORRECTION DESITISTICATION NUMBER: A BUILDING COMPLETED NALE OF PROVIDEE OR GUPPLEN 16548 BURDING 0023202016 PRARL VALLEY REMABILITATION & HEALTHGARE CENTER O ETREET ADDIESD, CITY, STIVE, 2P CODE 601 E FOLK 6T WASHINGTON, IN & STARLEWH OF DEPENDENCES BURDINGTON, IN & STARLEWH OF DEPENDENCES In PARL VALLEY REMAINT OR LECITENTORS (RECENDENT STULL In PROVIDERS PLAN OF ORSECTION In PRETAR VALLEY REMAINT OR LECITENTORS (RECENDENT STULL In PRETAR VALLEY REMAINT OR DEPENDENT In PRETAR VALLEY REMAINT OR LECITENTORS (RECENDENT STULL In PRETAR VALLEY REMAINT OR LECITENTORS (RECENDENT STULL) In F 334 Confinued from page 77 MDS coordinator runso stated it was a standing physician admission code to a drininister flue tuberculin skin test to all residents on admission, Resident #Th tend contendove the required tuberculin skin test or the preumococcal vaccines are required but bacculin skin test or the preumococcal vaccines as a code of the activity, the fally could not individual material contactines are required to the drininity of matina a study of Prevand ((manurouscol vaccines on readients) whom should have received It. F 334 During an interview on 6/23/16 at 11:10 a.m., the MDS coordinator runso stated the fally could not in fally matina as apply of Prevand ((manurouscol vaccine) or calibratis the regulation for the state of the fally could not in fally matina as apply of Prevand (from the fally refuse assistance of two statif remembers for baching, and habitorio divestatif remembers for bac	CENTER	S FOR MEDICARE &		· - T					
NAME OF PROVIDER OR GUPUER STREET ADDRESS, GTV, STATE, ZIP CODE end & POLKET STREET ADDRESS, GTV, STATE, ZIP CODE end & POLKET PEARL VALLEY REHABILITATION & HEALTHGARE CENTER O WISHINGTON, IA, 52353 (M) ID PRETM TWO BUILATION & HEALTHGARE CENTER O WISHINGTON, IA, 52353 (M) ID PRETM TWO BUILATION & HEALTHGARE CENTER O ID PRETM EXCHORENSE AT INFORMATION PRETM EXCHORENSE PARKET CONTRECTOR (EXCHORENSE ADDRESS OF THIL REGULATORY OR LISO DENTRY INS INFORMATION TO STREET ADDRESS, GTV, STATE, ZIP CODE end State of The page 77 (MD) ID CONTRECTOR ADDRESS, GTV, STATE, ZIP CODE end State of The page 77 (MD) ID CONTRECTOR ADDRESS, GTV, STATE, ZIP CODE EXCHORENSE ADDRESS, GTV, STATE, ZIP CODE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (D) CONTREL ADDRESS, GTV, STATE, ZIP CODE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (D) CONTREL ADDRESS, GTV, STATE, ZIP CODE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (D) CONTREL ADDRESS, GTV, STATE, ZIP CODE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (D) CONTREL ADDRESS OF CONTREL ADDRESS (D) CONTREL ADDRESS OF CONTREL ADDRESS OF CONTREL (D) CONTREL ADDRESS OF CONTREL (D) CONTREL ADDRESS OF CONTREL (D) CONTREL ADDRESS OF CONTREL ADDRESS OF CONTREL ADDRESS OF CONTREL ADDRESS OF CONTREL ADDRESS OF CONTREL (D) CONTREL ADDRESS OF CONTREL ADDRESS OF CONTREL ADDRESS OF CONTREL ADDRE				1					
PRABL VALLEY REHABILITATION & HEALTHCARE CENTER O BIT BOLK ST WASHINGTON, ILL 2000 PREAL VALLEY REHABILITATION & HEALTHCARE CENTER O BIT BOLK ST WASHINGTON, ILL 2000 PREAL VALLEY REHABILITATION & HEALTHCARE CENTER O D PREAL VALUEY R			165453	B. WING				06	/23/2016
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O WASHINGTON, IA 5235 PAID PREFIX NO SUMMARY STREMENT OF DEFICENCIES (Exc. Hencellace) WARY REFREENCE OF FULL REGULATION ON LSC DENTERING MARY REFREENCED BY FULL REGULATION ON LSC DENTERING MARY REFREENCED BY FUL REGULATION ON THE STATEMENT ON THE OCCUPANTIE DEFICIENCY AND AND REGULATION OF THE ONE AND AND AND TO CONNECTION RESIDENCE ON THE INFORMATION OF THE ONE AND AND AND AND AND AND AND REFERENCED BY FUL REGULATION OF THE ONE AND	NAME OF P	ROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZI	CODE		
Prefro REACH CORRECTIVE AND BENDEDED SYNULL PREFX REACH CORRECTIVE AND BENDED BY OULL DISCULTOR BY OULL DISCULTOR OF ALCOMMUNICY COMMANDED F 334 Continued From page 77 F 334 F 334 DS coordinator nurse stated It was a standing pytholatin admission order to administer the tubercalls skin test to all realidents on admission, Resident #7 had nan received the required tubercalls skin tests to residents as a standing puthoes and tubercalls skin tests to residents as a standing puthoes and tubercalls skin tests to residents as a standing puthoes and tubercalls skin tests to resident as a standing the facility aware that resident the required tubercalls skin tests to residents as a standing avare that resident as a sequely of the facility aware that resident the activity to the facility outid not information a support of Proven (preumococcal vaccine as a ordered. F 3.4 Authoes and the adding the facility outid not information as sequely of Proven (preumococcal vaccine as a ordered. Authoes and the facility could not information as sequely of Proven (preumococcal vaccine) and Staff G had not admistered puer unorder to estident the resident with intext memory. The MDS documented that the resident with intext memory. The bating, and had bifteral lower calending with the resident with the resident and face of the to residents with the resident and that the resident and that the resident with the resident second staff or the state and the second staff or the state and preumococcal vaccinations per the facility policy. Upon record review the resident second lacked documentation of the to resident with the preumococcal vaccinations per the facility policy. Upon record review the res	PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O						
 P 334 Continued Prom page 77 P 334 P 334 P 33	PREFIX	(EACH DEFICIENC	Y MUSY BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIA		COMPLETION
	F 334	MDS coordinator nura physician admission of tuberculin skin test to Resident #7 had not to Uberculin skin test or Staff G, Licensed Pra- supposed to administ and tuberculin skin test but had not performe- aware that residents if skin tests and pneum ordered. During an interview of MDS coordinator nura not indefinitely mainta (pneumococcal vacci administered pneumo whom should have re 3. The MDS dated 4/ documented the resid MDS revealed that the extensive assistance bathing, and had bilai weakness. The MDS resident had Parkinso disorder, and heart fa The Physician's Order 4/13/16 directed staff the pneumococcal, ar per the facility policy. Upon record review fit documentation of the vaccinations being ac	se stated it was a standing order to administer the all residents on admission, received the required the pneumococcal vaccines or pneumococcal vaccines sis to residents as required d the activity, the facility had not received tuberculin acoccal vaccines as n 6/23/16 at 11:10 a.m., the se stated the facility could ain a supply of Prevnar ne) and Staff G had not onla vaccines to residents aceived it. 14/16 for Resident#1 tent with intact memory. The e resident required of two staff members for teral lower extremily documented that the on's disease, a seizure ilure r with the signed date to provide the resident with nd annual flu vaccinations the residents record lacked flu or pneumococcal iministered.	F	334	Please Dec a	Hacha	d	8-17-16
FORM CMS-2587(02-99) Provious Varsions Obsolete Event (D:DJLG11 Facility ID: IA0948 If continuation sheet Page 78 of 98		1				. 10. 180040	14		Dago 70 of 09

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STATEMENT	RS FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DA	<u>IO. 0938-039</u> TE SURVEY MPLETED
		165453	B. WING	M	0	6/23/2016
NAME OF	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
PEARLV	ALLEY REHABILITATION	& HEALTHCARE CENTER O		H E POLK 8T ASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE AGTION) CROSS-REFERENCED TO THE/ DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 334	Continued From pag Coordinator reported	e 78 that she could not find resident's vaccinations.	F 334	Plase Dee att	achad	8-17-10
SS=E `	483.30(a) SUFFICIE PER CARE PLANS	NT 24-HR NURSING STAFF	F 353			8-17-1
	provide nursing and maintain the highest					
	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:			Please See at	tached	
	Except when walved section, licensed nur personnel.	l under paragraph (c) of this raes and other nursing		ψu		
	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.	nust designate a licensed				
	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.					
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Aug	. 5. 2016 2:54	PM All American Care	à.		No. 2043	P. 13/14 PRINTED: 08/05	/2016
		ND HUMAN SERVICES				FORM APPR OMB NO. <u>0938-</u>	OVED
STATEMENT	<u>S FOR MEDICARE &</u> of deficiencies correction	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	1
		165453	B. WING			06/23/2016	3
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	PCODE		
PEARLV	ALLEY REHABILITATION	& HEALTHGARE GENTER O		001 E POLK ST WASHINGTON, IA 52353			
(X4) (Ö PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAĢ	PROVIDER'S PLAN (EAGH CORRECTIVE <i>)</i> CROSS-REPERENCED T DEFICI	ACTION SHOULD BI		
F 353	 During the residem at 1:48 p.m. 6 of 6 re lights can take up to and sometimes staff come back. All the re either had watches of 2. During observation call light went on for constant observation to the call light at 2:5 3. The Minimum Dat tool, dated 5/12/16, 1 #9 which included ca (stroke) and diabetes indicated the residem assistance of 2 staff and personal hygien staff for transfers, toi MDS listed the residen for Mental Status) so moderately impaired The care plan for Re slated the resident re for bathing/showerin The facility Call Light directed staff to resp manner to rule out a improve resident sat During an interview of Resident #9 stated h than 15 minutes for light. The resident s recently as the night stated he/she has had 	It group Interview on 6/21/16 sidents reported that call 2-3 hours to get answered, will shut off the light, and not esidents reported that they r clocks to keep time. In on 6/21/16 at 2:35 p.m. a room number 103. With a staff member responded 3 p.m. ta Set (MDS) assessment listed diagnoses for Resident erebrovascular accident a mellitus. The MDS al required extensive for bed mobility, dressing, e, and totally depended on 2 let use, and bathing. The ent's BIMS (Brief Interview sore as 9 out of 15, Indicating cognition. stdent #9, revised 4/25/16, equired assistance from staff g and perineal cares. t policy, dated 5/21/15, ond to call lights in a timely n emergency situation and to	F 35	3 Aleast See C	ttach	xd	2-16

FORM CM3-2567(02-99) Previous Versions Obsolete

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Event ID:0JLG11

Facility ID: 1A0948

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If continuation sheet Page 80 of 98

	Aug	. 5. 2016 2:551	PM All American Care			No. 2043	P. '	14/14	
I	DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	D: 08/05/201 MAPPROVE 0. 0938-039	
	STATEMENT (DF DEFIGIENCIE8 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		XONSTRUCTION		e Survey Pleted	
			165463	B. WING			06	/23/2016	
		ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		901	REET ADDRESS, CITY, STATE, 21P CODE I E POLK ST ASHINGTON, IA 52353			
	(X4) ID PREF(X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) YAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCEO TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
	F 353	Continued From page The resident stated th a low life".	e 80 nis makes him/her feel "like	\$7	353	Please Dee atte	thed	8-17-14	
O^	F 356 \$\$=F	on 6/22/16 at 5:08 p.r answer call lights with 483,30(e) POSTED N		F3	356	· · ·		7-26-16	
		The facility must post a daily basis: o Facility name.	the following information on						

by the following categories of licensed and unlicensed nursing staff directly responsible for please see attached - Licensed practical nurses or licensed vocational nurses (as defined under State law). 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 in a prominent place readily accessible to

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.

o The total number and the actual hours worked

The facility must maintain the posted dally nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

FORM CMS-2567(02-99) Provious Versions Obsolete

o The current date.

resident care per shift: - Registered nurses,

o Resident census.

- Certified nurse aides.

o Clear and readable format,

residents and visitors.

Event ID: OJLG11

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Facility ID: IA0948

If continuation sheet Page 81 of 98

STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DA	IO. 0938-03 TE SURVEY MPLETED
		165453	B. WING	,	0	6/23/2016
	ROVIDER OR SUPPLIER	I & HEALTHCARE CENTER O		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E POLK ST WASHINGTON, 1A 52353		
(X4) ID PREFIX TAG	(EACH DEF(C)ENC	IATEMENT OF DEFICIENCIES Y MUSY BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	lould be	(X5) CONPLETA DATE
F 356	Continued From pag	e 81	F 35	8		7-26-1
	Interviews, the facility number and actual h daily basis as require census of 60 residen Findings Include: Observation on 6/20/ staff posting, dated 6 board behind the Sta accessible to resider posting identified a c The posting remaine following observed d 6/20/16 at 3:14 p.m. 6/21/16 at 6:11 a.m., 4:08 p.m. 6/22/16 at 5:53 a.m. On 6/22/16 at 11:03	/16 at 1:07 p.m. revealed a i/8/16, posted on a bulletin ition 1 nurses station and not its or visitors. The 6/8/16 ensus of 59 residents. d without change at the ates/ilmes: and 4:34 p.m. 8:47 a.m., 11:09 a.m. and a.m., a staff posting dated		Please Del atta	Chod	•
	at the same location, On 6/23/16 at 10:20 posting remained po	on top of the 6/8/16 posting , wilh census of 58 Identified. a.m., the 6/22/16 staff sted without updale. on 6/23/16 at 10:20 a.m., the				
	Director of Nursing s was responsible for t not aware there was between 6/8/16 and	tated the night shift nurse the dally staff posting, and not an updated staff posting 6/22/16, and relocated the board in the common hallway				

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		ND HUMAN SERVICES				OMB NO	MAPPROVE
ATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		(X3) DATE SURVEY COMPLETED 06/23/2016		
		165453	B. WING	-			
IAME OF PF	ROVIDER OR SUPPLIER		1 1	REET ADDRESS, CITY, STA	TE, ZIP CODE		
EARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O	1	ASHINGTON, IA 52353	ļ		
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEPICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefix Tag	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOUL CED TO THE APPROF EFICIENCY)	DBE	(X5) COMPLETIC DATE
5.050			F 356				126-1
F 356	During an Interview of Administrator stated the posting that would near the Station 1 mil	on 6/23/16 at 10:21 a.m., the she would get a frame for Id be located below the clock urses station and expected	1,000	Alease s	ee atta	Clad	
F 362 SS≂E	483.35(b) SUFFICIE PERSONNEL	rm daily as required. INT DIETARY SUPPORT	F 362				8-17-1
	The facility must em personnel competen the dictary service.	ploy sufficient support It to carry out the functions of					
	by: Based on observali resident interviews, meals in a timely ma	T is not met as evidenced ons, staff interviews, and the facility failed to provide anner for 2 of 2 meals ty reported a census of 60		Pleas Dee	l Artac	h <i>eo</i> l	
	Findings include:			·			
	1:48 p.m. 6 of 6 resi are not on time. The breakfast is to be se 11:00 a.m., and dim at least an hour late	group interview on 6/20/16 at dents reported that the meals residents reported that prved at 7:00 a.m., lunch at her at 5:00 p.m., but they are . Three of 3 residents who reported that room trays can hours late.					
	dated 6/22/16 which	t an alternate menu for lunch n Included ham and cheese ont and cheese, fruit, and wax					

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Aug	5. 2016 2:56	PM All Ame	rican Care			No. 2044		-
	VENT OF HEALTH AN							08/05/2018
	S FOR MEDICARE &						OMB NO.	0938-0391
STATEMENT (DF DEFICIENCIES CORRECT(ON	(X1) PROVIDER/SUPP (DENTIFICATION)	LIER/CLIA		CONSTRUCTION		(X3) DATE (COMPL	
		1654	53	Ð. WING			06/2	3/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY,	STATE, ZIP CODE		
				61	91 E POLK ST			
PEARL VA	LLEY REHABILITATION	& HEALTHCARE G	ENTER O	N I	ASHINGTON, IA 52			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIEN 37 Must be preceded 180 identifying info	BYFULL	id Prefix Tag	(EACH CORF	R'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD RENCED TO THE APPROPI DEFICIENCY)	BE	(X5) Completion Date
F 362	Observation on 6/22 the main dining room lunch. Observation on 6/22 food served to the re- Observation on 6/22 Staff C, Cook, stirred stove. During an Interview of C reported the elbow macaroni and chees Observation on 6/22 the residents served macaroni and chees and the CCDI unit. Observation on 6/22 the dietary staff start cheese Observation on 6/22 Staff FF, Registered dietary staff with whit CCDI (Chronic Conf of the facility. Observation on 6/22 CCDI dining unit car distribution to the re-	 (16 at 11:25 a.m. references in the of residents references in the of the second products of the second product products of the second product product product products of the second product prod	ady for evealed no evealed on the on the on the on the evealed all requested oom trays, evealed mont and vealed the to the in the lness) unit vealed the r	F 362	Plac	asi a attac		<i>.Ţ-17-16</i>
	Observation on 6/22 room trays delivered Observation on 6/22	l to the floor. 2/16 revealed that t						
FORM CM8-22	dinner tray served a 87(02-99) Previous Versions O		Event ID: 0,1LG f1	<u> </u>	adility ID: 1A0948	lf con	línualion shee	LPage 84 of 98

		PM All American Care			No.		D; 08/05/2016
		ND HUMAN SERVICES					APPROVED
STATEMENT C	S FOR MEDICARE & F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	<u> </u>	(X3) DATE	
		165453	B. WING	·		06/	23/2016
NAME OF PF	OVIDER OR SUPPLIER		9	TREET ADDRESS, CITY, 4	STATE, ZIP GODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O	1	01 E POLK ST VASHINGTON, IA 523			
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTRMENT OF DEFICIENCIES YY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR CROSS-REFER	RIS PLAN OF CORI ECTIVE ACTION & ENCED TO THE A DEFICIENCY)	Hould Be Ppropriate	(X6) Completion Date
F 362	Continued From pag	e 84	F 362				7-26-16
	Director of Nursing r	on 6/22/16 at 3:30 p.m. the aported that breakfast is to n., lunch at 11:00 a.m., and :00 p.m		Please	All a	rtfalhad	1
F 364 SS=F		FRITIVE VALUE/APPEAR,	F 364			£	7-26-16
	food prepared by me	es and the facility provides athods that conserve nutritive pearance; and food that is and at the proper		Ploa	V ø att	alhed	
	by: Based on observati review, the facility fa for 1 of 1 noon meal reported a census o Findings include: Observation on 6/22 following food tempo the lunch meal servi 140 Fahrenhelt (F): Waxed beans: 118 of degrees F, and mad Review of the facility Preparation, Steam directed staff that ho or higher and may n more than 30 minute During an interview Consultant reported leadership.	/16 at 2:00 pm revealed the eratures after completion of ce failed to be maintained at legrees F, little smokies: 110 and cheese: 132 degrees F. / policy, Safe Food able, revealed the policy it foods must be 135 degrees ot stay in the steamtable for			ų (, (, (, (, (, (, (, (, (, (, (, (, (,		
FORM CMS-25	87(02-99) Previous Versions O	baciete Event ID:0/L0)ii F2	acility ID: TA0948		If continuation sha	et Page 85 of 88

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Aug	. 5. 2016 2:56F	PM All American Care					NO. 2044	r. 5	
		ID HUMAN SERVICES); 08/05/2016 APPROVED
		MEDICAID SERVICES							0938-0391
	of Deficiencies	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTH	PLE CONSTRUC	TION			(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDIN	G				CUMP	LETED
		165453	B. WING					06/	23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDR		, STATE, ZI	PCODE		
PEARL V	LLEY REHABILITATION	& HEALTHCARE CENTER O		691 E POLK S WASHINGTO	•	289			
				WASHINGIN			OF CORRECTION		(X5)
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX		EACH COR	RECTIVE A	CTION SHOULD B		COMPLETION DATE
TĄG		LSC IDENTIFYING INFORMATION)	TAG	CR	COSS-REFE	RENCED T DEFICIE	O THE APPROPRE (NCY)	ATE	DALE
L		· · · · · · · · · · · · · · · · · · ·							
E 064	Dentinger Fram more	. 05	F 3	84			·		7-26-110
F 364		60 60				Λ.,	- A LAN	Yhad	1 WIY "4
	dietary training. During an interview o	n 6/22/16 at 2:45 p.m. the		$ P \alpha$	asl	ΨU	atta	HU	
		orted that the kitchen staff		1	-		atter		1
	didn't have dietary fra	aining.							7-26-16
F 371		CURE,	F 3'	71					7 614 14
SS=F	STORE/PREPARE/S	ERVE - SANIJARY							
	The facility must -								
	(1) Procure food from	n sources approved or							
		ry by Federal, State or local							
	authorities; and	مغيالينهم مسط ممسيم فمصا							ļ
	(2) Store, prepare, di under sanitary condit	stribute and serve food							
	under samtery contait	10113							
					^				
					Man	Λ <i>Λ</i>			
					puu	YY (
	This REQUIREMEN	Is not met as evidenced			1		attal	Shed	· .
1	by:				≯-	LEL	w		
		m, staff Interviews, and			•				
		colley/procedures, the facility							
	tailed to prepare; dist	iribule; and serve food under nd failed to check food					· · ·		
	temperatures after th	e puree process for 3 of 3		ļ					
	residents and prior to	the service of lunch and						1	
	dinner for 57 residen	ts. The facility reported a							
1	census of 60 residen	18.							
1	Findings include: Observation on 6/22/	16 at 12 pm Identified Staff							
	Y, cook, and began t	o serve food. Three plates of							
	waxed beans were s	et wilhout temperature of all							
		on the steamtable. The							[
	surveyor prompted S temperatures of all for								1
1		16 at 12:45 pm Identified							
}	Staff Y, cook, culling	lhe meat and cheese							
	sandwiches while we	aring gloves. Staff Y, with							
	<u> </u>							<u> </u>	L

FORM CMS-2567(02-99) Previous Versions Obsolate

Pacility ID: 1A0948

If continuation sheet Page 86 of 98

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Aug. 5. 2016 2:56PM All American Care

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		D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/05/2016 M APPROVED D. 0938-0391
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		165453	Ð. WING			06	/23/2016
NAME OF P	ROVIDER OR SUPPLIER			ŝ	TREET ADDRESS, CITY, STATE, ZIP CODE		
ÞEARL W	LLEY REHABILITATION	& HEALTHCARE CENTER O			01 E POLKST VASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	AYEMENY OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	e Ate -	(X5) COMPLETION DATE
F 371	gloves on, then touch resident 's paper me cutting meat and che occurred 3 times. Observation on 6/22/ MDS coordinator can aerve sandwiches. T put a hair net on, don handle meat and ohe washing her hands. Observation on 6/22/ Y, cook, obtained the with pureed diets. M amokies, and waxed and placed on service the temperatures of it them to 3 of 3 residen diets. Observation on 6/22/ Y go to the handwast placed soap on his fit turn the water on and then went to sink at the water would not turn turned the water off of leaking out of the col floor. Staff Y then too out of right hand, dor with meal service. Observation on 6/22/ C, Cook, cut meat an gloves on, putting the unit trays, placed a lii cutting meat and che place five (5) times. Observation on 6/22/ and dinner revealed administrator wearing	his uniform and the al order and then returned to ese sandwiches. This 16 at 1:00 pm revealed the ne into the kitchen to help he staff person walked in med gloves then preceded to ese sandwiches without 16 at 1:45 pm revealed Staff trays ready for the residents acaroni and cheese, beans purced per guidelines e tray. Staff Y did not check he 3 items before serving nts that required purced 16 at 1:52 pm revealed Staff hing sink in the kitchen and ght hand. Staff Y went to 11 twould not turn on. Staff Y he dishwashing erea and the on. Maintenance staff had fue to handwashing sink tection buckets on to the k a paper towel; wiped soap med gloves then proceeded 16 at 2:00 pm revealed Staff of cheese sandwiches with a sandwiches on room and d on the plate then back to ese sandwiches. This took		371	Please Lee attorcha	:	7-76-16

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Aug. 5. 2016 2:57PM All American Care

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Entrement of Deproductions NOP PROVIDER ORDERTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION IDENTIFICATION NUMBER: IDENTIFICATION IDENTIFICATION NUMBER: IDENTIFICATION IDENTIFICATION NUMBER: IDENTIFICATION IDENTIFICATION NUMBER: IDENTIFICATION IDENTIFICAT	CENTER	S FOR MEDICARE & I	MEDICAID SERVICES	_			<u>OMB NC</u>	0938-0391 0.
NAME OF PROVIDER OR SUPPLIER JUNE OF PROVIDER OR SUPPLIER PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O STREET ADDRABS, CITY, STATE, ZP COCE GIT E POLING T MAGHINGTON, IA 52353 (M) ID PROV TAG SUMAAKY STATEMENT OF OF DEFINITION (EXCENT MOST RELEASED TO DEFINITION & HEALTHCARE CENTER O TAG PD DEFINITION & HEALTHCARE CENTER O STATE DEFINITION & HEALTHCARE CENTER O PROV TAG PD DEFINITION (EXCENT MOST RELEASED DEFINITION & HEALTHCARE OF DEFINITION (EXCENT MOST RELEASED DEFINITION (IA 52353) PD DEFINITION (EXCENT MOST RELEASED DEFINITION & HEALTHCARE OF DEFINITION (EXCENT MOST RELEASED DEFINITION (EXCENT MOST RELEASE				1				
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O Got E POLK ST WASHINGTON, IA, 52353 COULD WAYN YAO SUMMARY STRUMENT OF DEFICIENCIES PRACE STRUMENT ON CRESS DEFICIENCY MUST BE PRECIDED BYTULL PRACE ACCORRECTIVE ACTION STRUMENT PRACE ACCORRECTIVE ACTION STRUMENT ACCORRECTION ACCOUNT ACTION STRUMENT PRACE ACCORRECTIVE ACCOUNT ACTION STRUMENT PRACE ACCORRECTIVE ACCOUNT AC			165453	B. WING			06/	23/2016
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER 0 WASHINGTON, (A 52353 (%)D PRETX Trid Studmawy stratekent or percisences (ackor percisences) (ackor pe	NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ONE OF PRETX TAG SUMMARY STATEMENT OF DEFICIENCES PLAN DEFICIENCY MUST BE PRECEDED SYLL PAGE D PRETX TAG D PREFX TAG D PREFX TA	PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O					
With Trop PREAM DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY ON LIG DESTRICTION ACTION SHOULD BE CROSS-REFERENCED OF HEAD DEFICIENCY Continued From page 87 F 371 Continued From page 87 F 371 F 371 F 371 Continued From page 87 F 371 F 371 F 371 Continued From page 87 F 371 Image: Substance of the substance o	-				['			
F 3/1 Continued From page 67 Frage across the base of foes with another strap below it. The delician helped prepare and serve food multiple times. The administrator wore wedges with a thick strap at the base of foes. The administrator wore wedges with a thick strap at the base of foes. The administrator helped wash dishes and in the food preparation and aevice area multiple times. Observation on 6/22/16 at 5:0 pm revealed the surveyor needed to prompt Staff 2, cook, to check the temperatures of all food prior to serving the dimer 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 tiffeen seconds, sanifizing your thermometer as you move from one food tem to the next. The policy directed staff to achieve the following temperatures; meats 165 degrees Fahrenhelt; firesh, forzen or canned fuilt and vegetables 165 degrees Fahrenhelt. During an interview on 6/21/16 at 6:45 a.m. Staff D, Cook, reported the kitchen lacked leadership. During an interview on 6/21/16 at 6:45 p.m. the MDS Coordinator reported the kitchen staff did not have dietary realming. During the initial kitchen tour on 6/20/16 at 9:300 a.m. to 10:12 a.m., identified to collewing concerns: the walk-in-refigerator contained a large roast beef cooked in a 4 quart plasito contained a large or between the staff of dated or dated, a 1.75 pound package of perperving.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIM		COMPLETION
dated, a 22.4 pound box of Farmland meat directly on the floor, 16 ham and cheese	F 371	strap across the base below it. The dietician food multiple times. The wedges with a thick s The adminisitrator hele food preparation and Observation on 6/22/ surveyor needed to pic check the temperature the dinner meal. Review of the facility if Food Preparation, dire cooking temperatures following internal temp fifteen seconds, saniful you move from one for policy directed staff to temperatures; meats fresh, frozen or canned degrees Fahrenheit; if 165 degrees Fahrenheit; if	of toes with another strap a helped prepare and serve l'he administrator wore trap at the base of toes. ped wash dishes and in the service area multiple times. 16 at 5:30 pm revealed the rompt Staff Z, cook, to es of all food prior to serving policy/procedure titled, Safe ected staff to obtain final s; foods must reach the peratures for a minimum of (zing your thermometer as nod item to the next. The achieve the following 165 degrees Fahrenheilt; ad fruit and vegetables 165 poultry and stuffed foods eit. in 6/21/16 at 6:45 a.m. Staff a did not receive any dietary in 6/22/16 at 2:45 p.m. the orted the kitchen staff did ng. en tour on 6/20/16 at 9:30 entified the following refrigerator contained a ed in a 4 quart plastic labeled or dated, a 1.75 operoni, not sealed or tox of Farmland meat	F	371			7:Ab-16

FORM CMS-2567(02-99) Provious Versions Obsolete

Event (0:0JLG11

Facility ID; (A0948

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No. 2045 P. 1/43

	MENT OF HEALTH AN S FOR MEDICARE &						FORM	08/05/2018 APPROVED 0938-0391
STATEMENT C	of deficiencies Correction	(X1) PROVIDER/SUPP IDENTIFICATION N	LIER/CLIA	• •	GONSTRUCTION		(X3) DATE 5 COMPL	
		1654	53	B. WING		<u> </u>	06/2	3/2016
NAME OF PI	TOVIDER OR SUPPLIER	I		s	TREET ADDRESS, CITY,	STATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE C	ENTER O		01 E POLK ST /ASHINGTON, IA 52	353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficien Y Must be preceded LSC (dentifying Infoi	BY FULL	iù Prefix Tag	(EACH CORN	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X6) Completion Date
F 371	Continued From page sandwiches on a coor dated, a box of 15 do directly on the floor, a mozzarella cheese h dated. The walk-in-re- moderate amount of shredded carrots, che The kitchen work are plastic container full o measuring cup in the white three-tiered pla moderate amount of floor in the prep area the dishwasher conta silverware, food debu under the dishwasher had a sticky surface. sink, contained 2 fou white floor tiles. The the food prep table c of various sizes. The contained a cloudy a table contained a gril There were no saniti The meat silcer had debris, it was not bei Both Vulcan ovens h carbon build up insid contaíned a greasy s The griddle to the sta up. The backsplash carbon build up. The contained a greasy, steamtable contained	kle sheet not cove izen pasteurized eg a 5 pound plastic b alf full and unseale frigerator floor con food debris to Inclu- eese, and butter pa- a contained a 22 q of flour, with a one flour directly on th istic food cart, cont food debris. The ki , under the sink, an alned the following is, a plastic orange r. The entire kitche Under the handwa r inch by four inch blue-green colored ontained several ci- countertops in the ppearance, the me ity surface with foo zer buckets in the i a cloudy film on it v ing used and was u ad a moderate am e, and the outer de aufface with food di- bove contained grea- of the stove contain- sheif above the ov fuzzy surface. Abo d an air vent with b	ggs ag of itained a itained a itaine	F 371	Plea	asi el attai		7-276-16
	kitchen contained a moderate amount of	gummy surface wit food debris. The n	h a nlik cooler					
FORM CMS-25	contained 27 4 ounc		Event ID:0JLG11	l Fi	l	if contin	uation shee	1 Page 89 of 98

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No. 2045 P. 2/43

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. E	OMB NO. 0938-035 NULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED ING 06/23/2016
165453 6.5	00,20,4010
NAME OF PROVIDER OR SUPPLIER PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	STREET ADDRESS, CITY, STATE, 2IP CODE 601 E POLK ST WASHINGTON, IA 52353
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFIC)ENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LEC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION (X5) REFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
 F 371 Continued From page 89 of strawberry Mighty shakes, and 40 4 curce 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 slicky 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 tce cream. The service hallway between the dry storage, and kitchen entrance revealed a floor coated with a thin fayer of dirt. There were no cleaning schedules posted in the kitchen, service hallway floor, welk-in-freezer, walk-in-refrigerator, appeared same as the Initial tour, and no cleaning schedules were found. Observation on 6/21/16 at 10:15 a.m. revealed concerns from the initial kitchen tour remain the same, and the walk-in-refrigerator also now included a 4 quar container half full of beets without a date. 	F371 7=26-14 Alease Dee attachad

A11 A

2/12 2045 D

CENTER		ID HUMAN SERVICES MEDICAID SERVICES				OMB I	NO. 0938 <u>-03</u>
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMGER:	(X2) MULTIP A. BUILDING				te Survey Mplgted
		165453	B. WING			(6/23/2016
NAVEOSO	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP CODE		
				601 E PC	LK ST		
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O		WASHI	IGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IOENTIFYING INFORMATION)	id Prefix Tag		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLO 8E	(X5) Compleyio Dave
]						7-26-1
F 371	Continued From page	90 ·	F 37	71			1 00
	Observation on 6/21/	16 al 3:24 p.m. revealed		1			
	Initial kitchen tour co	ncerns remained the same.					
	Į						
	The Facility Cleaning	and Sanitizing Policy					
		wing: Surfaces are to be					
		anitized after each use, and					
	following any interrup	otion of operations when			0		
	contamination may h	ave occurred. The			Please Der attack		
		s of grills, griddles and			VIDE		
	similar cooking devic	es, and the cavities and door wens are to be cleaned at	1		1		
	seals of microwave o	pd-contact surfaces of all			a allad	ind	
	cooking equipment a				Jos attain	VA	
	encrusted grease de	nosite and other			Vac P		
	accumulated soll All	work surfaces are to be					
	cleaned, and sanitize						
	clean-as-you-go.						
	The Food Storage P	olicy documented the					
	following: Food remo						
	packaging is to be pr	otected from contamination,					
	by storing in clean, c	overed, sanitized containers.					
	Food containers are	to be stored a minimum of 6	1				
		or to protect food from					
	splash, contaminatio	n, and at a height to prevent					
	easy cleaning of the	storage area. All items are to					
		oor, including all cardboard	1				
	boxes.	o to the difference of the					
	The facility policy for	Safe Food Preparation					
		facility will monitor and aration of all foodstuff,		1			
		hazardous food, to prevent					
	food-borne lílness. T	hazaluus loou, io provent ha policy directed					
		as staff member, will be					
		le concentration of sanitizer					
	and the cleanliness of						
		ent will be cleaned with		l			
		zed between uses. Gloved					
2	hands are considere		1	1			3

Aug. 5. 2016 2:58PM All American Care

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No. 2045 P. 4/43

		ND HUMAN SERVICES MEDICAID SERVICES		· · · · · · · · · · · · · · · · · · ·		M APPROVED D. 0938-0391
STATEMENT	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE SURVEY COMPLETED	
		165453	B. WING			/23/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
0040130		& HEALTHCARE CENTER O				
PEAKL W		I & REALINDARE OLIVIER O		WASHINGTON, IA 52353	· · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y Must be preceded by full LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 371	surface that can beck scolded. Failure to ch contributes to cross-of gloves are single used disposed of after each During an interview of B, Staff C, and Staff they have tried to cal he will not answer. Th Dietary Supervisor he month. During an interview of Administrator reported able to get a hold of th that different slaff me During an interview of facility Dieticlan Cons had been able to get supervisor. The Dietit been working with th dietary staff has a lot reported staff are han reported staff are han reported staff are han reported staff are han service so it has an of Dieticlan reported the	ome contaminated or nange gloves between tasks contamination. Disposable e items and must be in use. In 6/21/16 at 6:45 a.m. Staff D all cooks reported that I the Dietary Supervisor, but he staff reported that the ad been at the facility for a on 6/21/16 at 10:11 a.m. the to that they had not been the Dietary Supervisor, and ombers have tried to call him. In 6/21/16 at 4:00 p.m. the suitant reported that nobody in contact with the dietary clan reported that she had e current staff, and the to learn. The Dietician on under part-time facility since December. The porking with the dietary staff d to meal substitutions, the how to organize meal organized system. The e kitchen tacked leadership.	F 37			7-26-14
:	8:36 a.m. and 11:09 not sanitize the dinin conclusion of the bre funch meal was serve	ation on 6/21/16 between a.m. Identified the staff did g room tables after the akfast meal and before the ed. On 6/21/16 at 10:51 blaced paper placemats on solete Event 10:04		≪achity ID: 1Aô948	If continuation she	

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P. 5/43 No. 2045

CENTERS	S FOR MEDICARE &	MEDICAID SERVICES). 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROV(DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAYE Comp	PLETED
		165453	B. WING			06/	23/2016
NAME OF PR	OVIDER OR SUPPLIER			51	TREET ADDRESS, CITY, STATE, ZIP CODE		
					n e Polk st		
PEARL VA		N & HEALTHCARE CENTER O		W	ASHINGTON, (A 52353		F
(X4) ID PREFIX TAQ	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES IGY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	id Prefi TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRID DEFICIENCY)	ILD BE	(X5) Completion Date
							2-17-14
F 371	Continued From pa			371			
	the dining room tab	les and over wet water rings breakfast beverages. Plated					
	lunch meals were p	laced on top of the placemats.			Please ser att	alla	
	During an interview	on 6/22/16 at 7:13 p.m., the and licensed distician (RDLD)					
	stated a sanitizer w	as available in the kitchen and					
	stelf should sanitize	the dining room tables					
	between each mea			441			
	483.65 INFECTION SPREAD, LINENS	I CONTROL, PREVENT	F	44			7-24-14
55°D							
	The facility must es	tablish and mainiain an					
	Infection Control Pr	ogram designed to provide a comfortable environment and					
	to help prevent the	development and transmission					
	of disease and infe	clion.					
	() to for ellers () and re-	Destaw			please See atta		
	(a) Infection Conirc	tablish an infection Control			fiel the	AL . I	
	Program under whi	ch It -			Del attu	ula	
		nirols, and prevents infections			, jen-		
	in the facility:	rocedures, such as isolation,					
	should be applied t	o an individual resident; and					
	(3) Maintains a rec	ord of incidents and corrective					
	actions related to it	nfections.					
	(b) Preventing Spre	ad of Infection	ł				
	(1) When the Infec	tion Control Program					
	determines that a r	esident needs isolation to					
	prevent the spread isolate the resident	of infection, the facility must					
	(2) The facility mus	t prohibit employées with a					
	communicable dise	ase or infected akin lealons					
		with residents or their food, if ransmit the disease.					
	T OTHER CONTRACT WILL		1				

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID; 1A0948

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Aug. 5. 2016 2:59PM All American Care

No. 2045 P. 6/43

PRINTED	08/05/2016
FÖRM /	APPROVED

		MEDICAID SERVICES				<u>D. 0938-0391</u> - PUDV6V
	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENT(FICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		≅ SURVEY PLETED
		185453	B. WING		06	/23/2016
NAME OF PF	ROVIDER OR SUPPLIER	······································	1	TREET ADDRESS, CITY, STATE, 21P CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		01 E POLK ST VASHINGTON, IA 52353		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y Must be preceded by full SC identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION 8 CROSS-REFERENCED TO THE AF DEPICIENCY)	Hould be	(X6) Completion Date
F 441	Continued From page hands after each díre hand washing is Indio professional practice. (c) Linens	ct resident contact for which ated by accepted	F 441			7-26-14
	Personnel must hand	le, store, process and to prevent the spread of		Please Dec atte	ached	
	by: Based on observatio interview, the facility to infection control mean utilizing a glucometer and falled to properly 1 of 9 residents observed	Is not met as evidenced n, record review, and falled to carry out adequate sures for 2 of 2 residents (Residents # 22 and #23) dispose of soiled linens for rved during personal cares acility reported a census of		y see the		
	Findings include: 1. The Admission red a diagnosis of diabete	cord for Resident #22 listed as metilitus.				
	Staff G, Licensed Pra a blood sample with t #22 to check the resi After completing the I wiped the glucometer G did not leave the S glucometer for any m	n on 6/21/16 at 7:02 a.m., actical Nurse (LPN) obtained he glucometer for Resident dent's blood sugar level. blood sugar check, Staff G r off with a Sani-cloth. Staff ani-cloth in contact with the easurable period of time.				
	2. The Admission red a diagnosis of diabete	cord for Resident #23 listed as mellilus.				

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No. 2045 P. 7/43

DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES				ED: 08/05/2016 RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	Q. 0938-0391
TATEMENT	DF DEFICIENCIES	(X1) PROVIDER/&UPPL ER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A, BUILDING	ONSTRUCTION		E SURVEY (PLETED
		165453	Ð, WING		0	6/23/2016
NAME OF PI	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP COL)E	
			601	e polk st		
PEARL VA	LLEY REHABILITATION	A HEALTHCARE CENTER O	WA	SHINGTON, IA 52353		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RECTION	000)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	SAPPROPRIATE	COMPLETION DATE
F 441	Continued From pag	e 94	F 441		·· ,	7-26-16
	During an observatio	n on 6/21/16 at 6:58 a.m.,				
		ad a blood sample with the				
	glucometer for Resid					
	resident's blood suga	ar level. After completing the				-
	blood sugar check, S	Staff G wiped the glucometer				
		Staff G did not leave the				
		with the glucometer for any		_		
	measurable period of	f time.				
				Please		
	Staff G utilized the sa				1. alkad	
	Residents #22 and #	23.		Please see at	FUCILICA	
				fill		
		on 6/22/16 at 5:00 p.m., the		*		
		tated staff should cleanse				
		an alcohol wipe and leave				Ì
		/ith the glucometer for 2		ι. Ι		1
	minutes.	10014C at 12:00 pm revealed				
		/20/16 at 12:20 pm revealed s: disposable incontinence				
		t cover sheet on Resident				
		sident's room door. The				1
		to dark yellow stains visible				
		lloor. The resident's room				
	also contained a stro					
		/21/16 at 8:20 am revealed				
		s: disposable bed pad and				
		esident #4's floor by the				
	entrance to the reside	ent's room. The room				
		k yellow stains visible on the				
						1
	COMPS and Cleaned al	are spars or when day inten				
RM CM8-256	urine saturated linem one white sock on Re entrance to the resid contained light to dar linens. The room com smell over the linens. During an interview of V, Housekeeper, rep dirty linen. Staff V in cleaning and sees dii will bag them, place to place, and spray dish it dry. When asked I	s: disposable bed pad and esident #4's floor by the ent's room. The room it yellow stains visible on the stained a strong urine odor on 6/22/16 at 10:15 am Staff orted staff are to dispose of dicated when he/she is rty linen on the floor, he/she them in the appropriate infected on the area then pat how the carpet in resident's fiter spills or when dirty linen	311 Facilit	y ID: 140948	If continuation she	el Page 9t

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		ND HUMAN SERVICES				FORM APPR OMB NO: 0938	
TATEMENT	S POR MEDICARE Q PF DEFICIENCIES CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		165453	B. WING			06/23/201	6
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	00/25/2010	<u> </u>
PEARL VÀ	LLEY REHABILITATION	N & HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 523	53		
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F 441 F 467 SS=E	Is a large area the fa shampooers that will spot, it can be clean During an interview of Staff Development O are completed twice bathing and other AD guidelines. The Staff reported that If Issue corrected at the time offered on the apot to 483.70(h)(2) ADEQU VENTILATION-WIND	floor Staff V reported that if it cility has 2 carpet be used. If it is a smaller ed by hand. on 6/22/16 at 9:30am the coordinator reported, audits a week to ensure peri-care, DLs are being completed per f Development Coordinator s are noted, the staff is an issue is noted and aining. JATE OUTSIDE DOW/MECHANIC e adequate outside of windows, or mechanical	F 44	Please See	attacha	7 II 1 7-20	_
	This REQUIREMEN' by: Based on observatio failed to ensure adec the facility. The facili residents. Findings include: 1. Observation upon 10:30 a.m. revealed specialized behavior station. 2. Observation on 6/	Γ is not met as evidenced on and interview, the facility juste odor control throughout ity identified a census of 60 initial tour on 6/20/16 at a strong smell of urine in the al unit near the nursing 20/16 at 10:45 a.m. revealed e in the hallway of the 600		Please Dee	attach	led	

FORM CMS-2567(02-99) Previous Versions Obsolete

Fedility ID: 1A0948

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Aug. 5. 2016 3:00PM All American Care

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No. 2045 P. 9743

		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED FORM OMB NC	APPRO	OVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION		(XS) DATE COMP	Survey Leteo	
		165453	B, WING	<u>. </u>		06/	23/2016	3
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353				_
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUSY BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CRO89-REFERENCED TO TH DEFICIENCY	n Should Bi E appropru		(X5) COMPLE DAT	RTION
F 467	a strong smell of urin behavioral unit near t 4. Observation on 6 <i>i</i> p.m. revealed a stror hallway of the 600 H 5. Observation on 6 <i>i</i> 12:00 p.m. revealed hallway of the 600 H During an interview of N, Certified Nursing <i>J</i> unit smelled like urin to the trash which sta During an interview of Director of Nursing a smelled urine in the was a heavily inconti the facility planned to with the rather than of 6. Observation on 6 a strong urine odor in Resident's room sme walking into Resider saturated linens: disj and cover sheet on 1 door. Light to dark y linens that were on t smell hovered over 1 stated the recimer is room felt humid, air personal fan had bed the resident request to leaving.	 /21/16 at 6:30 a.m. revealed the nursing station. /21/16 at approximately 2:00 ng small of urine in the all. /22/16 at approximately a strong smell of urine in the all. /22/16 at approximately a strong smell of urine in the all. /22/16 at approximately a strong smell of urine in the all. /22/16 at approximately a strong smell of urine in the all. /22/16 at approximately a strong smell of urine in the all. /22/16 at 6:30 a.m., Staff Assistant, acknowledged the e and stated it might be due aff had not taken out yet. /22/16 at 5:08 p.m., the icknowledged she had 600 Hall. She stated there inent resident in the hall and o move him/her to a room 	F 46			had	7-26	-16
	87/02-00) Proving Versions Of			Fedlity ID: 1A0948	ff continu	uation shae		 97 of 98

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No 2045 P 10/43

Aug	. 5. 2016 3:001	PM All American Care	3	No. 204	5 P.	10/43
		ID HUMAN SERVICES			FOR	D: 08/05/2016 MAPPROVED
STATEMENY	<u>(S FOR MEDICARE &</u> OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		E CONSTRUCTION	(X3) DATE	<u>D. 0938-0391</u> Esurvey Pleted
		165453	B. WING	<u> </u>	06	/23/2016
NAME OF P	Rovider or supplier		- <u>-</u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O	1	801 E POLK BT WASHINGTON, IA 52353		
(X4) 10 Prefix Tag	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	360.	(X6) Completion Date
F 467	Resident #4 sat in the of urine. Noted urine and one white sock of entry door. Light to d the linens were on the smell hovered over th 8. Observation on 6/2 very strong urine, alm coming from Residen in resident's room. Co Nurse Alde, placed a recliner before the res 9. Observation on 6/2 Resident #4's room an smelled of urine. During an interview on V, Housekeeper, repor dirty linen. Staff V ind cleaning and sees dirt will bag them, place th place, and spray disin it dry. When asked h rooms are cleaned aft had been left on the fi is a large area the fac	e recliner. The room smelled salurated linens: chux pad n Resident #4's floor by ark yellow stains visible on a floor. A strong urine odor e linens. 21/16 at 9:00 am revealed ost ammonia like, smell t #4's hunter green recliner observed Staff S, Certified disposable bed pad on the sident sat down. 22/16 at 7:30 pm revealed nelled a little better, but still n 6/22/16 at 10:15 a.m. Staff orted staff are to dispose of licated when he/she is by linen on the floor, he/she nem in the appropriate fected on the area then pat ow the carpet in resident's er spills or when dirty linen oor Staff V reported lihat if it littly has 2 carpet be used. If it is a smaller	₩ 467	Please	ched	77761

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IJLG11

Facility ID: 1A0948

If continuation sheet Page 98 of 98

Aug. 5. 2016 3:00PM All American Care

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No. 2045 P. 11/43

PRINTED: 07/25/2016 FORM APPROVED

TATEMENT	IENT OF INSPECTIO OF DEFICIENCIES • CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SU COMPLE	
ND FLAN OI		IA0948	B. WING			3/2016
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	OVIDER OR SUPPLIER	601 F PO				
EARL VA	LLEY REHABILITATION	I & HEALTHGARE CI WASHIN	GTON, IA 52353		<u> </u>	
	CIBRINDY C	ATEMENT OF DEFICIENCIES	a	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI	ECTION HOULD BE	(X5) COMPLETE
(X4) ID PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CURRENT OF THE AF CROSS-REFERENCED TO THE AF DEFICIENCY)	PROPRIATE	OATE
L1093	58.12(1) Admission,	transfer, and discharge	L1093			
	58.12(135C) Admis	sion, transfer, and discharge.		1.00 1	0 L	8-17-1
I	58.12(1) General ad	lmission policies.		please A attached	~	חיוס
	I. For all residents re	alding in a health care facility		" attached	1	
	receiving reimburse	ment through the medical under lowa Code chapter		a		
	249A on July 1, 200	and all others subsequency				
	admitted, the facility	shall collect and report	1			
	Information regardin	ng the resident's eligibility or benefits through the Federal				
	nonariment of Vele	rans Affairs as requested by	i			
	the lowa commissio	n on Veterans Affairs. The				
	facility shall collect:	and report the information on	1			
	forms and by the pr	ocedures prescribed by the on veterans affairs. Where				
	lowa commissions	ility may also report such				
	Information to the l	owa department of human				
	eonices in the évé	ent lhat a resident is unable to				
	assist the facility in	obtaining the information, the				1
	facility shall seek th	ne requested information from y members or responsible				
	party.	A Manimara of Leabourging				
	For all new ad	missions, the facility shall				
	onliest and report t	he reguired information				
	regarding the resid	ent's eligibility or potential				
	eligibility to the low	a commission on veterans us of the resident's admission.				
	Eor regidents resid	ing in the facility as of July 1,				
	2003 and prior to	May 5, 2004, the facility shall				
	collect and report	the required information				
	remarding the resid	jent's eligibility or potential				
	eligibility to the low	ve commission on veterans ays after May 5, 2004.				
	lf a resident is	aliaible for benefits through the				
	foderal Departmen	nt of Affairs or other third-party				
	nevor the facility	shall seek reimbursement from	ł	•		1
	euch henefits to th	ne maximum extent available mbursement from the medical				
DIVISIPN O	OF HEALTH FACILITIES	STATE OF IOWA PERMANAPLIER REPRESENTATIVE'S SIGNA				(X6) DATE
LABORATO		FILLAN.	l	Administrator	8	<u>4-16</u>
(U)	MUUL(/C	7 MUN	6399	0JLG11	if con	Unuation sheet

Aug. 5. 2016 3:00PM All American Care

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No. 2045 P. 12/43

PRINTED: 07/25/2018 FORM APPROVED

DEPARTA	IENT OF INSPECTIO	NS AND APPEALS			(X3) DATE SU	RVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	COMPLET	
AND PLAN O	FCORRECTION	DEMILISCATION NOSCEN	A. BUILDING:			
			B. WING		06/23	2016
		IA0948	D, 99(01/3			· <u>····</u>
NAME OF PE	OVIDER OR SUPPLIER	STREETAD	ORESS, CITY, STAT	e, zip code		
		601 E PO				
PEARL VA	LLEY REHABILITATION	I & HEALTHGARE GI WASHING	TON, IA 52353		T ADDRETION	(X5)
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ļ			L1093			
L1093	Continued From pag		L1090			
	assistance program	established under Iowa Code	1			
	chapter 249A.					
	The provisions of the admiral	of this paragraph shall not on of an Individual as a		POLLE		
	resident to a state m	ental health institute for			,	
Į	acute psychiatric car	re or to the admission of an		please	uarhod	
	individual to the low	a Veterans Home. (II,III)			HALL WIN	
			1			
	This Signita is not t	net as evidenced by:				
4	Based on record rev	tew and staff interviews, the				
	facility failed to ensu	ire that residents eligible for				
	veteran benefits we	re entered on the facility's	ļ			
1	Current Resident St	ummary (CRS form) report for rds reviewed (Residents #15,				
1	#19 and #20). The f	acility reported a census of 60	1			
	residents.					
	Findings include:					
ĺ	Review of the facilit	y's Resident Admission				
1	Reports and CRS r	eport revealed:				1
			8			
ł	1. Resident #15 Wa	as admitted to the facility on i at the facility until 5/30/16,				
1	and was not assess	sed for véteran benefils				
	eligibility.					
1		t the fit of the little of the				
	2. Resident #19 w	as admitted to the facility on				
	3/22/16, remained	at the facility at the time of on 6/23/16, and was not				
	assessed for veter	an benefits eligibility.				
1	3. Resident #20 w	as admitted to the facility on				
	1/11/16/16, remain	ed at the facility at the time of				
	survey completion	on 6/23/16, and was not an benefits eligibility.	ļ			
1				н. 		
	During an Interview	y on 6/23/16 at 10:50 a.m., the				{
	Administrator state	ed the previous administrator				
DIVISION C	F HEALTH FACILITIES - S	ITATE OF IOWA	6893	OJLGÍI	lf conti	nualion sheet 2 o

STATE FORM

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All American Care Aug. 5. 2016 3:01PM

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No. 2045 P. 13/43

PRINTED; 07/25/2016 FORM APPROVED

DEPART	MENT OF INSPECTIO	NS AND APPEALS			
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN C	of Correction	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		IA0946	B. WING		06/23/2016
		140840			1 ++1=+1=+ ×
NAME OF P	ROVIDER OR BUPPLIER	STREET AU	DRESS, CITY, ST	ATE, ZIP CODE	
		601 E PO	LK ST		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CI WASHING	STON, IA 5235	3	
	ALL	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N (X5)
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				DEFICIENCY	
1 4000	O		L1093		
L1093	Continued From page	e z	Elicot		
		esident veteran benefit			
	eligibility assessment	t, unable to locate the			
	records for Resident's	\$ #15, #19 and #20, and			
	messages left that re	quested return calls from the		1 VIAA AD	
	previous administrato	r had gone unanswered.	1	Please att	
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DIVISION OF	HEALTH FACILITIES - STA	TE OF IOWA			
STATE FORM			6889	0.)LG11	Y continuation sheet 3 of 3

STATE FORM

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 designce 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 Administrator 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.

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. ٠
- New washcloths and towels were ordered, received and distributed on 6/27/16. ٠
- Other residents with the potential to be affected by the current practice will be identified and the П. 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.
- The following measures will be put in place and/or systemic changes will be made to ensure the III. current practice does not reoccur.
- All resident rooms will be inspected daily by the Director of Maintenance/designee. ٠
- 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. .

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

- 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.

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. ٠
- To determine if other residents may be affected the Director of Nursing or designee have ĬĨ. reviewed all residents feeding plan of care and by direct obvestvation 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.

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

- 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 ٠ 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 ٠ recommendation for one month.

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.
- 11. 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.

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.
- The Director of Nursing or designee have reviewed all residents feeding plan of care and speech IĬ. 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.
- The facility has implemented the following system changes to prevent reoccurrence. m.
 - 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 dally 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 ٠ 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.

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.

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- 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

F309

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.

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.
- The Director of Nursing or designee have reviewed all residents in facility with potential to be IĬ. affected by residents behaviors that may result in a decrease of resident observation and safety.
- The facility has implemented the following system changes to prevent reoccurrence. III.
 - 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 muse's station by Director of Nursing or designce.
 - 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 ٠ 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 ٠ recommendation for one month.

Date of Completion July 26 2016

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.

All residents who have had an unplanned discharge to the hospital within the last 30 days were IÍ. 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.
- The following measures will be put in place and/or systemic changes will be made to ensure the III. current practice does not reoccur.
 - All nursing staff have been re-educated on medication administration procedures including ٠ immediate report of medication error.
 - Nursing staff were education on facility medication error policy and procedure. ٠
 - 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

F329

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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.

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 electronio 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.

P353

- 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 lowa, 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.

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 dictary 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 bave 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.

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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.

F441

- 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.

F441

- 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 noncompliant.
- 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.

F467

- 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 noncompliant.
- 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.

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.
- Other residents with the potential to be affected by the current practice will be identified and the II. following corrective actions will be taken.
- Administrator or designee has audited all current residents admissions documentation folder for any ٠ missing VA Eligibility clearance.
- The following measures will be put in place and/or systemic changes will be made to ensure the III. 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. ٠
- The following will be completed and monitored to the quality assurance program. ١٧.
 - The Administrator and Administrative Assistant have developed an audit tool to monitor ٠ 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.