STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	C 02/02/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Amended on July 13, 2017 Correction Date 3-1-17 The following deficiencies relate to the investigation of Complaints #64501-C, #64703-C, #65028-C, #65257-C, #65464-C and Incident #65086-I. See Code of Federal Regulations (42CFR), Part 483, Subpart B-C.	F 000	please see attached.	3-1-17
F 223 SS=D	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, family and staff interviews and review of policy and procedures, the facility failed to ensure that each resident was free from abuse (Residents #4 and #9) due to altercations with Resident #8 #5. The facility reported a census of 60 residents. Findings include:	F 223		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 03/13/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	Continued From page 1 1. Resident #9 had a MDS (Minimum Data Set) assessment with a reference date of 10/29/16. The MDS identified the resident had diagnosis including hypertension (high blood pressure), non-Alzheimer's dementia and fracture of the cervical spine (neck area). The MDS indicated the resident score 15 of 15 points on the Brief Interview for Mental Status (BIMS) test. A score of 15 identified the resident had no cognitive problems. The MDS indicated the resident experienced no delirium symptoms and required extensive assistance by 1 or more staff members for bathing. The care plan identified the resident had the potential to be verbally aggressive regarding dementia. The interventions related to dementia problem, (initiated 10/21/16), with interventions that included: 1. Analyze key times, places, circumstances, triggers and what escalates the behavior and document. 2. Assess resident's understanding of the situation, allow time for the resident to express self and feelings towards the situation. 3. A new intervention, the resident moved to a separate room, was added on 12/21/16. Resident #9's Progress Notes (nurse's notes) identified the following entries: On 12/20/16 at 11:00 a.m., Staff J, a contracted agency licensed practical nurse (LPN), stated a certified nursing assistant (CNA) reported this resident and room mate (Resident #8) yelled in their room. As she approached the resident's room Resident #9 came out of his/her room and stated Resident #8 just choked him/her while sitting in the recliner. Staff J stated she told the	F 223	Please see attached	3-1-17

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F 223	Continued From page 2 resident not to return to the room and at the approximate same time, Resident #8 came out of the room, passed Resident #9 and there was a verbal exchange between the 2 residents. The 2 residents were separated and Resident #9 agreed to have lunch in his/her room. 12/20/16 at 11:10 a.m., Staff J documented she assessed the resident's neck, no marks noted, the resident stated Resident #8 squeezed his/her neck but not hard enough to leave marks. 12/20/16 at 11:30 a.m., Staff J documented the administrator was not in the building at the time, the Director of Nursing was notified of the event. A signed written statement dated 12/20/16 at 11:00 a.m. by Staff J, documented the musing assistant informed her of Resident #8 and Resident #9 yelling at each other. When she went to check, Resident #9 said Resident #8 just choked him/her. Staff J stated she directed the resident to stay in the dining room. When Resident #8 passed by Resident #9, they exchanged verbal aggressions. Resident #8 stated Resident #9 moved the curtains and would not move them back so he/she choked her/him. All 3 of Staff J's entries were lined through, with notation "Incorrect Documentation" recorded at 12:08 p.m. on 12/20/16. The facility policy and procedure titled Abuse, Neglect and Exploitation dated 11/21/12, included and directed staff to do the following: Each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. Residents	F 223	Please See attached	3-1-17

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F 223	Continued From page 3 must not be subject to abuse by anyone, including, but not limited to, facility staff, other residents, staff of other agencies serving the resident, or other individuals. The Abuse coordinator in the facility is the DON, Administrator, or facility appointed designee. Report allegations or suspected abuse immediately to the Administrator, other officials in accordance with state law, and the State Survey and Certification agency (Iowa DIA) through established procedures. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Physical abuse includes, but not limited to hitting, slapping, pinching and kicking. Initiate an investigation immediately for allegations of abuse. Notify the attending physician, resident's family/legal representative and Medical Director. Obtain witness statements, following appropriate policies. Contact the State Agency and the local Ombudsman office to report the alleged abuse. Monitor and document the resident's condition, including the response to medical treatment or nursing interventions. Document actions taken directed by the policy in the resident's record. A written statement dated 12/20/16 and signed by Staff E stated she walked down Hall #2, past the resident's room, and heard both residents yelling	F 223	Please See Attached	3-1-17

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F 223	Continued From page 4 and cursing at each other [Resident #8, #9]. A written statement dated 12/20/16 and signed by the DON and Staff H, registered nurse (RN), stated Resident #9 said he/she and their room mate, Resident #8, yelled and cursed at each other, denied that he/she had been choked, then both Resident's #8 and #9 defended each other, Resident #8 wanted to continue to see Resident #9's dog when it visited. The 2 residents argued all the time but refused to move from each other's room. Observations throughout the investigation revealed both Resident's #8 and #9 ate all meals in the same dining room at the same time. During an interview on 1/18/17 at 1:03 p.m., Staff J stated on 12/20/16, Staff E, an agency CNA, informed her the residents yelled at each other, Staff J went to their room, Resident #9's face was red and she could tell by how he/she acted that something had happened and they were upset, he/she did not have their neck brace on and stated his/her room mate got out of bed, came over to where he/she was and choked them. She directed this resident out of the room to the hall, then Resident #8 came out of the room, the 2 cursed at each other and she separated them. Resident #8 told her he/she choked Resident #9. Staff J stated she tried to notify the administrator and the DON for 30 minutes without success, then reported the incident to Staff K, the MDS Nurse, and Staff K reported the incident to the DON, in the kitchen at the time. Staff J stated she assessed Resident #9, did not identify any injuries and started documentation of the event when the administrator arrived and instructed her that she needed to follow protocol, not to chart it,	F 223	Please See attached.	3-1-17

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F 223	Continued From page 5 yelled at her when she saw that she had already charted on it, directed her to strike it out, and they (the facility) would take care of it. The owners came to the facility the same day, spoke with both residents and moved this resident to another room. During an interview on 1/18/17 at 2:02 p.m., Staff E, CNA, stated she worked on 12/20/16, on her way past Resident's #8's and #9's room she heard them yell at each other, on her return past the room the argument continued and was heated, she informed the nurse, Staff J. During an interview on 1/18/17 at 3:40 p.m., Staff L, facility owner, stated he spoke with the Administrator and Residents #8 and #9 on 12/20/16. Resident #8 stated he/she choked his/her room mate in the dining room and Resident #9 denied the room mate had choked him/her. The owner stated the Administrator reviewed security video of the dining room, did not see any such activity and concluded it had not occurred. When asked if he spoke to the staff on duty at the time of the event, the owner stated he only spoke to the Administrator. Resident #9 was moved to a larger room because the Administrator stated Resident #9 was jealous of Resident #8 and the source of their arguments, and the facility had not taken other action on the matter. During an interview on 1/18/17 at 4:05 p.m., Resident #9 stated his/her room mate tried to choke him/her about a month ago as he/she sat in their recliner chair, demonstrated with his/her hands how Resident #8 placed their hands on this resident's neck, moved to another room after it happened but continued to see Resident #8 in	F 223	Please see attached	3-1-17

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F 223	Continued From page 6 the facility and wanted nothing to do with the resident. During an interview on 1/18/17, Resident #9's family member stated about a month ago they went to visit and found the resident moved to a different room, spoke to someone in the office who said the resident was moved because he/she was not nice to the room mate. The resident told the family member that his/her room mate had tried to choke them when they visited that day. During an interview on 1/19/17 at 3:30 p.m., Resident #9's responsible party (power of attorney - POA) stated the facility notified him/her that they moved the resident to another room because he/she didn't get along with the room mate, the next time when he/she visited, the resident said his/her room mate had tried to choke him/her. The POA stated the resident seemed happier in the new room and he/she didn't want to take action on the matter as the family had sought transfer to another facility and thought that would happen soon. 2. Resident #8 had a MDS with a reference date of 12/27/16. The MDS identified the resident had diagnoses that included hypertension (high blood pressure), diabetes, malnutrition and chronic kidney disease. The MDS indicated a BIMS test identified a score of 13. A score of 13 identified no cognitive problems but did have symptoms of delirium present, had verbal behaviors directed at others that occurred 1 to 3 of the previous 7 days. The MDS revealed the resident could transfer from bed to chair without assistance, required extensive assistance of at least 1 staff person for bathing and unable to ambulate.	F 223	Please see attached 3-1-17	

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F 223	Continued From page 7 The care plan included a potential for being verbally aggressive. The interventions directed the staff to do the following: When the resident becomes agitated, intervene before agitation escalates, guide away from source of distress, engage calmly in conversation. If response is aggressive, staff to walk calmly away and approach later. In a written statement dated 12/20/16, the DON stated Resident #8 reported the resident thought he/she placed Resident #9 in a head-lock in the main dining room around 11:15 a.m. to 11:30 a.m. During an interview on 1/18/17 at 4:20 p.m., Resident #8 stated he/she had a room mate last month but he/she thought the resident was jealous of him/her, they fought a lot and the room mate moved to another room, he/she still sees that resident at the facility but the resident doesn't talk to him/her. On 2/2/17, Staff C was interviewed (interim DON) stated Resident #8 has always had behaviors, striking out and irritable. This behavior was nothing new and just the resident. 3. Resident #4 had a MDS assessment with a reference date of 1/1/17. The MDS indicated the resident had diagnoses that included diabetes, depression, chronic pain and other mental disorder due to known physiological condition. The resident scored 14 on the BIMS test. A score of 14 reflected the resident had no cognitive impairments. The care plan indicated the resident had a potential for verbal aggression problem. The	F 223	Please See attached	3-1-17

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F 223	Continued From page 8 interventions directed the staff to: 1. Monitor behaviors every shift. Document observed behavior and attempted interventions. 2. Psychiatric/Psychogeriatric consult as indicated. Progress Notes (nurse's notes) included the following entry: On 12/5/16 at 4:58 p.m. - Resident reported that other resident hit him/her with a purse and wanted to press charges. Police interviewed both residents, this resident called the other resident a name and the other resident hit this resident with a purse. Police officer instructed the resident not to call the other resident names. No injuries evident, no other actions taken. The note was transcribed by the facility social worker. The record did not reveal documentation of an assessment or other actions related to the alleged abuse, or the behaviors assessed every shift as directed in the nursing care plan. During an interview on 1/24/17 at 1:10 p.m., Resident #4 stated another resident wheeled past his/her room in a wheel chair, swung a purse that hit him/her on their foot ankle area as they sat in a wheel chair in the doorway of their room, and it hurt him/her. The resident stated he/she had called the other resident a name, but the other resident often called this resident names, he/she wanted the police called and charges pressed, he/she talked to the social worker about it, the police arrived and told him/her not to call the other resident names. During an interview on 1/26/17 at 10:44 a.m., the	F 223	Please see attached	3-1-17

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F 223	Continued From page 9 facility social worker (SW) stated while in his office he heard a commotion that came from the direction of the resident's room but did not observe what had occurred. After that Resident #4 presented in his office, said Resident #5 hit him/her with a purse, wanted to call the police and then left. Resident #5 told the SW Resident #4 called him/her names and he/she was tired of it and swung their purse at Resident #4 that hit them. Resident #4 returned again, pushed by a CNA that said the DON said he should call the police. The SW notified the police, the officer spoke with both of the residents and advised Resident #4 not to call Resident #5 names and advised Resident #5 not to swing their purse, no other actions taken by the police. The SW said he looked at Resident #4's foot and didn't see a mark, the resident said it didn't hurt, so he did not notify the nurse and he had not discussed the matter with either the DON or the administrator. During an interview on 1/26/17 at 11:02 a.m., Staff B, CNA, stated Residents #4 and #5 don't like each other and often called each other horrible names. Staff B stated she worked the day that Resident #5 hit Resident #4 with a purse but had not witnessed it, and that was the only time their exchanges went beyond name-calling that she was knew about. During an interview on 1/25/17 at 3:05 p.m., the interim DON stated she could not find an incident report or investigation report on the 12/5/16 resident to resident altercation. 4. The MDS Assessment tool dated 12/9/16 revealed Resident #5 had diagnoses that included hypertension (high blood pressure), wound infection and morbid obesity, scored 15	F 223	Please see attached	3-1-17

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F 223	Continued From page 10 out of 15 points possible on the Brief Inventory of Mental Status (BIMS) cognitive assessment without symptoms of delirium, verbal behaviors directed at others that occurred 1 to 3 of the previous 7 days, and required extensive assistance of at least 1 staff member for bathing and toileting, unable to ambulate and without deficit of any extremity. The nursing care plan included a behavior problem with interventions that included: 1. Intervene as necessary to protect the rights and safety of others (initiated 1/2/16). 2. Is known to go to other residents rooms and say things to upset them (initiated 4/22/16). 3. Remind resident not to stare in other resident's rooms (initiated 3/8/16). Progress Notes (nurse's notes) revealed the following entries: On 12/5/16 at 3:30 p.m. transcribed by Staff H, RN - Resident was in front of Resident #4's room, screamed an obscenity and swung his/her purse, instructed resident to stop behavior immediately, resident stated the other had called him/her a name, directed resident to go down the hall and resident stated he/she didn't have to. Resident escorted back to his/her room. On 12/5/16 at 5:03 p.m. transcribed by the SW - Other resident reported Resident #5 hit him/her with their purse and wanted to press charges. Police contacted, interviewed both residents and reported the other resident called this resident a name and this resident hit the other with their purse. Officer instructed the other resident not to call this resident names. No injury reported, no further action taken by police.	F 223	Please see attached	3-1-17

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F 223	Continued From page 11 On 12/6/16 at 3:04 p.m. transcribed by Staff H - After further investigation resident did not come in contact with other resident with his/her purse. Resident stated he/she thought they hit the wheelchair or door frame. This resident was in his/her wheel chair outside of the doorway in the hall, swung a short handled purse at Resident #4 seated in a wheel chair inside their room and 1 foot away from the doorway. During an interview on 1/24/17 at 2:25 p.m. Resident #5 stated Resident #4 called him/her names, and tired of it. Resident #5 stated she/he swung the purse at the resident and struck them on their feet when they were seated in a wheel chair some time before Christmas. Resident #5 stated the police came and told him/her not to swing the purse. The resident denied he/she called Resident #4 names, unless that resident called them names first. The facility policy and procedure titled Abuse, Neglect and Exploitation policy dated 11/21/12 directed staff to do the following: Each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. Residents must not be subject to abuse by anyone, including, but not limited to, facility staff, other residents, staff of other agencies serving the resident, or other individuals. The Abuse coordinator in the facility is the DON, Administrator, or facility appointed designee. Report allegations or suspected abuse immediately to the Administrator, other officials in	F 223	Please See Attached.	3-1-17

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F 223	Continued From page 12 accordance with state law, and the State Survey and Certification agency (Iowa DIA) through established procedures. "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. "Physical Abuse" includes, but not limited to hitting, slapping, pinching and kicking. Initiate an investigation immediately for allegations of abuse. Notify the attending physician, resident's family/legal representative and Medical Director. Obtain witness statements, following appropriate policies. Contact the State Agency and the local Ombudsman office to report the alleged abuse. Monitor and document the resident's condition, including the response to medical treatment or nursing interventions. Document actions taken directed by the policy in the resident's record.	F 223	Please See attached	3177
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who-	F 225		

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	165453	A. BUILDING _____ B. WING _____	C 02/02/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 13 (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 225	Please See Attached	3-17

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F 225	Continued From page 14 accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interview and review of policy and procedures, the facility failed to notify the Iowa Department of Inspections and Appeals (DIA) of resident to resident abuse. The incidents involved Resident #9,#8 and Resident #4,#5. The facility reported a census of 60 residents and the sample consisted of 12 residents. Findings include: 1. Resident #9 had a MDS (Minimum Data Set) assessment with a reference date of 10/29/16 revealed Resident #9 had diagnoses that included hypertension (high blood pressure), non-Alzheimer's dementia and fracture (cervical spine, the neck area of the spine). The resident had a BIMS (Brief Interview for Mental Status) test score of 15. A score of 15 identified the resident had no cognitive problems.	F 225	Please See Attached	3-1-17

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F 225	Continued From page 15 The care plan identified a potential for having verbally aggressive behavior related to dementia problem, (initiated 10/21/16). The interventions directed the staff to do the following: Analyze key times, places, circumstances, triggers and what escalates the behavior and document Assess resident's understanding of the situation, allow time for the resident to express self and feelings towards the situation. A new intervention indicated the resident moved to a separate room and added on 12/21/16. Resident #9's Progress Notes (nurse's notes) revealed the following entries: On 12/20/16 at 11:00 a.m., Staff J, a contracted agency licensed practical nurse (LPN), stated a certified nursing assistant (CNA) reported this resident and room mate (Resident #8) yelled in their room. As she approached the resident's room, Resident #9 came out of his/her room and stated Resident #8 just choked him/her as they sat in the recliner. Staff J told the resident not to return to the room and at the approximate same time, Resident #8 came out of the room, passed Resident #9 and there was a verbal exchange between the 2 residents. The resident's were separated and Resident #9 agreed to have lunch in his/her room. 12/20/16 at 11:10 a.m., Staff J documented she assessed the resident's neck, no marks noted, the resident stated Resident #8 squeezed his/her neck but not hard enough to leave marks. 12/20/16 at 11:30 a.m., Staff J documented the	F 225	Please See Attached	3-1-17

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F 225	Continued From page 16 administrator was not in the building at the time, the director of nursing was notified of the event. Review of the Departments records, identified the facility did not contact the Iowa Department of Inspections and Appeals of an abuse between Resident #9 and Resident #8. A written statement dated 12/20/16 and signed by Staff J stated the CNA informed her Resident's #8 and #9 yelled at each other, when she went to check Resident #9 said Resident #8 just choked him/her. She directed the resident to stay in the dining room when Resident # 8 passed by in a wheel chair and the 2 exchanged verbal aggressions. Resident #8 stated Resident #9 moved the curtains and wouldn't move them back "so I choked him/her". Paged DON and administrator twice, couldn't find either. Assessed Resident #9's neck, no injuries identified. Found DON in kitchen and notified her, she stated she had to stay in the kitchen to help during lunch, that was more important. Started to chart what was said between the residents when the administrator came in and she notified her of the incident. She continued to chart the rest of what was said and was told not to chart until they investigated. A written statement dated 12/20/16 and signed by Staff E stated she walked down Hall #2 past the resident's room and heard them yelling and cursing at each other. A written statement dated 12/20/16 and signed by the DON and Staff H, registered nurse (RN), stated Resident #9 said he/she and their room mate, Resident #8, yelled and cursed at each other, denied that he/she had been choked, then	F 225	Please See Attached 3-1-17	

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F 225	Continued From page 17 both Resident's #8 and #9 defended each other, Resident #8 wanted to continue to see Resident #9's dog when it visited, the 2 argued all the time but refused to move from each other's room. During an interview on 1/18/17 at 1:03 p.m., Staff J stated on 12/20/16, Staff E, an agency CNA, informed her the residents yelled at each other, Staff J went to their room, Resident #9's face was red and she could tell by how he/she acted that something had happened and they were upset, he/she did not have their neck brace on and stated his/her room mate got out of bed, came over to where he/she was and choked them. She directed this resident out of the room to the hall, then Resident #8 came out of the room, the 2 cursed at each other and she separated them. Resident #8 told her he/she choked Resident #9. Staff J stated she tried to notify the administrator and the DON for 30 minutes without success, then reported the incident to Staff K, the MDS Nurse, and Staff K reported the incident to the DON, in the kitchen at the time. Staff J stated she assessed Resident #9, did not identify any injuries and started documentation of the event when the administrator arrived and instructed her that she needed to follow protocol, not to chart it, yelled at her when she saw that she had already charted on it, directed her to strike it out, and they (the facility) would take care of it. The owners came to the facility the same day, spoke with both residents and moved this resident to another room. Staff J stated she had worked at other facilities and knew that this type of incident was a mandated report to the Iowa DIA, the administrator's actions and comments were disrespectful, unprofessional and upset her, and she filed a written statement and complaint about the matter with her employer.	F 225	Please See Attached	3-1-17

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F 225	Continued From page 18 During an interview on 1/18/17 at 2:02 p.m., Staff E, CNA, stated she worked on 12/20/16, on her way past Resident's #8's and #9's room she heard them yell at each other, on her return past the room the argument continued and was heated, she informed the nurse, Staff J. Later that day she overheard the administrator's loud voice when she was in the DON's office with Staff J and didn't sound like she was happy with Staff J or how she handled the incident. She wrote a statement and was called in to the DON's office later that day when the DON told her that her statement was pretty close to what the resident had said. Staff E stated she also provided a written statement to her employer. During an interview on 1/18/17 at 4:05 p.m., Resident #9 stated his/her room mate tried to choke him/her about a month ago as he/she sat in their recliner chair, demonstrated with his/her hands how Resident #8 placed their hands on this resident's neck, and this resident moved to another room after it happened. 2. Resident #8 had a MDS assessment with a reference date of 12/27/16. The MDS identified the resident had diagnoses that included hypertension (high blood pressure), diabetes, malnutrition and chronic kidney disease. The BIMS test scored the resident with a 13. A score of 13 represented no cognitive impairment. The MDS indicated the resident had verbal behaviors directed at others that occurred 1 to 3 of the previous 7 days. The care plan identified the resident had a verbal aggression problem, with interventions that included:	F 225	Please See Attached	3-1-17

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F 225	Continued From page 19 1. When the resident becomes agitated, intervene before agitation escalates, guide away from source of distress, engage calmly in conversation. If response is aggressive, staff to walk calmly away and approach later. In a written statement dated 12/20/16, the DON stated Resident #8 reported he/she thought they placed Resident #9 in a head-lock in the main dining room around 11:15 a.m. to 11:30 a.m. During an interview on 1/18/17 at 4:20 p.m., Resident #8 stated he/she had a room mate last month but he/she thought the resident was jealous of him/her, they fought a lot and the room mate moved to another room, he/she still sees that resident at the facility but the resident doesn't talk to him/her. 3. Resident #4 had a MDS assessment with a reference date of 1/1/17. The MDS indicated the resident had diagnoses that included diabetes, depression, chronic pain and other mental disorder due to known physiological condition. The resident scored 14 on the BIMS test. A score of 14 reflected the resident had no cognitive impairments. The care plan indicated the resident had a potential for verbal aggression problem. The interventions directed the staff to: 1. Monitor behaviors every shift. Document observed behavior and attempted interventions. 2. Psychiatric/Psychogeriatric consult as indicated. Progress Notes (nurse's notes) included the	F 225	Please see attached 3-1-17	

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F 225	Continued From page 20 following entry: 12/5/16 at 4:58 p.m. - Resident reported that other resident hit him/her with a purse and wanted to press charges. Police interviewed both residents, this resident called the other resident a name and the other resident hit this resident with a purse. Police officer instructed the resident not to call the other resident names. No injuries evident, no other actions taken. The note was transcribed by the facility social worker. The record did not reveal documentation of an assessment or other actions related to the alleged abuse, or the behaviors assessed every shift as directed in the nursing care plan. During an interview on 1/24/17 at 1:10 p.m., Resident #4 stated another resident wheeled past his/her room in a wheel chair, swung a purse that hit him/her on their foot ankle area as they sat in a wheel chair in the doorway of their room, and it hurt him/her. The resident stated he/she had called the other resident a name, but the other resident often called this resident names, he/she wanted the police called and charges pressed, he/she talked to the social worker about it, the police arrived and told him/her not to call the other resident names. During an interview on 1/26/17 at 10:44 a.m., the facility social worker (SW) stated while in his office he heard a commotion that came from the direction of the resident's room but did not observe what had occurred. After that Resident #4 presented in his office, said Resident #5 hit him/her with a purse, wanted to call the police and then left. Resident #5 told the SW Resident #4 called him/her names and he/she was tired of it and swung their purse at Resident #4 that hit	F 225	Please see attached	3-1-17

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F 225	Continued From page 21 them. Resident #4 returned again, pushed by a CNA that said the DON said he should call the police. The SW notified the police, the officer spoke with both of the residents and advised Resident #4 not to call Resident #5 names and advised Resident #5 not to swing their purse, no other actions taken by the police. The SW said he looked at Resident #4's foot and didn't see a mark, the resident said it didn't hurt, so he did not notify the nurse and he had not discussed the matter with either the DON or the administrator. During an interview on 1/26/17 at 11:02 a.m., Staff B, CNA, stated Residents #4 and #5 don't like each other and often called each other horrible names. Staff B stated she worked the day that Resident #5 hit Resident #4 with a purse but had not witnessed it, and that was the only time their exchanges went beyond name-calling that she was knew about. During an interview on 1/25/17 at 3:05 p.m., the interim DON stated she could not find an incident report or investigation report on the 12/5/16 resident to resident altercation. 4. The MDS Assessment tool dated 12/9/16 revealed Resident #5 had diagnoses that included hypertension (high blood pressure), wound infection and morbid obesity, scored 15 out of 15 points possible on the Brief Inventory of Mental Status (BIMS) cognitive assessment without symptoms of delirium, verbal behaviors directed at others that occurred 1 to 3 of the previous 7 days, and required extensive assistance of at least 1 staff member for bathing and toileting, unable to ambulate and without deficit of any extremity.	F 225	Please See attached	3-1-17

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F 225	Continued From page 22 The nursing care plan included a behavior problem with interventions that included: 1. Intervene as necessary to protect the rights and safety of others (initiated 1/2/16). 2. Is known to go to other residents rooms and say things to upset them (initiated 4/22/16). 3. Remind resident not to stare in other resident's rooms (initiated 3/8/16). Progress Notes (nurse's notes) revealed the following entries: On 12/5/16 at 3:30 p.m. transcribed by Staff H, RN - Resident was in front of Resident #4's room, screamed an obscenity and swung his/her purse, instructed resident to stop behavior immediately, resident stated the other had called him/her a name, directed resident to go down the hall and resident stated he/she didn't have to. Resident escorted back to his/her room. On 12/5/16 at 5:03 p.m. transcribed by the SW - Other resident reported Resident #5 hit him/her with their purse and wanted to press charges. Police contacted, interviewed both residents and reported the other resident called this resident a name and this resident hit the other with their purse. Officer instructed the other resident not to call this resident names. No injury reported, no further action taken by police. On 12/6/16 at 3:04 p.m. transcribed by Staff H - After further investigation resident did not come in contact with other resident with his/her purse. Resident stated he/she thought they hit the wheelchair or door frame. This resident was in his/her wheel chair outside of the doorway in the hall, swung a short handled purse at Resident #4	F 225	Please see attached	3-1-17

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F 225	Continued From page 23 seated in a wheel chair inside their room and 1 foot away from the doorway. During an interview on 1/24/17 at 2:25 p.m. Resident #5 stated Resident #4 called him/her names, and tired of it. Resident #5 stated she/he swung the purse at the resident and struck them on their feet when they were seated in a wheel chair some time before Christmas. Resident #5 stated the police came and told him/her not to swing the purse. The resident denied he/she called Resident #4 names, unless that resident called them names first. The facility's Abuse, Neglect and Exploitation policy dated 11/21/12 directed staff: 1. Each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. Residents must not be subject to abuse by anyone, including, but not limited to, facility staff, other residents, staff of other agencies serving the resident, or other individuals. 2. The Abuse coordinator in the facility is the DON, Administrator, or facility appointed designee. Report allegations or suspected abuse immediately to the Administrator, other officials in accordance with state law, and the State Survey and Certification agency (Iowa DIA) through established procedures. 3. "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. 4. "Physical Abuse" includes, but not limited to hitting, slapping, pinching and kicking. 5. Initiate an investigation immediately for	F 225	Please See Attached	3-1-17

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F 225	Continued From page 24 allegations of abuse. 6. Notify the attending physician, resident's family/legal representative and Medical Director. 7. Obtain witness statements, following appropriate policies. 8. Contact the State Agency and the local Ombudsman office to report the alleged abuse. 9. Monitor and document the resident's condition, including the response to medical treatment or nursing interventions. 10. Document actions taken directed by the policy in the resident's record. Review of the DIA reports on 2/27/17 at 11:00 a.m. determined the facility had not reported the incidents involving Residents #9 and #8 and Residents #4 and #5.	F 225	Please see attached 3-1-17	
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff	F 242		

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F 242	Continued From page 25 interviews, the facility failed to display respect and allow maximum flexibility when to receive a shower (Resident #6). The night shift staff awakened Resident #6 in bed, to receive a shower. The facility reported a census of 60 residents and the sample consisted of 12 residents. Findings include: 1. Resident #6 had a MDS (Minimum Data Set) assessment with a reference date of 11/16/16. The MDS identified the resident had diagnosis that included hypertension (high blood pressure), anxiety and depression. The BIMS (Brief Interview for Mental Status) indicated a score of 12 out of 15 points. A score of 12 reflected a moderate cognitive impairment. The MDS indicated the resident required extensive assistance of 1 staff member for bathing. The care plan included an activity of daily living (ADL) self-care deficit, with interventions that included 1 staff member assistance for bathing/showering twice weekly and as needed, on Tuesday and Saturday evenings. Shower records revealed the resident had 1 shower since 1/11/17, on 1/21/17. During an interview on 1/26/17 at 1:50 p.m., Resident #6 stated he/she had not had a shower in over 2 weeks when staff woke them at 10:30 p.m. on Saturday, 1/21/17, and instructed him/her they had to have a shower at that time because staff had to get showers caught up. The resident stated he/she did not like to be awakened for a shower late at night.	F 242	Please see attached	3-1-17

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 26 During a resident group interview, residents stated the facility had been short staffed, during the previous 2 weeks there were only 2 certified nursing assistants (CNA's) in the building on the 2:00 p.m. to 10:00 p.m. shift on at least 2 different days. One resident stated he/she had not had a shower for 9 days, another resident stated it had been over 2 weeks since their last shower, 1 resident stated if it wasn't for the Hospice staff he/she probably wouldn't get a shower, and the 4th resident stated they used to get 2 showers a week and now only receive 1 per week, but uncertain when their last shower was. All residents agreed that they required showers more often than the facility provided. Staff interviews revealed: On 1/25/17 at 4:55 a.m., Staff F, licensed practical nurse (LPN), stated Staff H, registered nurse (RN) and unit manager, directed the night shift CNA's to complete Resident #6's shower on the previous weekend. The staff awakened the resident during the 10 p.m. to 6 a.m. shift to give the shower to the resident. 1/26/17 at 8:45 a.m., Staff I, CNA, stated a shower schedule for every resident was located in a binder at the nurse's station, the CNA's have been instructed for the last couple of weeks that they have to have their showers done before they could leave.	F 242	Please see attached	3-1-17
F 312 SS=E	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 312		

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F 312	Continued From page 27 personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to provide bathing assistance at intervals that met hygiene requirements for at least 25 residents that included Resident's #2, #4, #6, #7, and 3 of 4 residents that participated in a group resident interview. The facility reported a census of 60 residents. Findings include: Review of resident bath and shower records on 1/24/17 identified 30 residents had not received a bath or shower since 1/11/17 and an additional 21 residents had only received 1 bath or shower in that time frame. 1. Resident #6 had a Minimum Data Set (MDS) assessment with a reference date of 11/16/16. The MDS identified the resident had diagnoses that included hypertension (high blood pressure), anxiety and depression. The MDS indicated the resident had a Brief Interview of Mental Status (BIMS) score of 12 out of 15. A score of 12 identified a moderate cognitive impairment. The MDS indicated Resident #6 required physical help with bathing. The care plan initiated on 5/12/16, identified the resident had a deficit with activities of daily living self-care due to weakness. The interventions directed one staff person to shower the resident twice a week and as necessary, Tuesday and Saturday evenings. Shower records identified the resident only received 1 shower since 1/11/17 and that date was documented as 1/21/17.	F 312	Please see attached	3-1-17

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F 312	Continued From page 28 During an interview on 1/26/17 at 1:50 p.m., Resident #6 stated he/she had not had a shower in over 2 weeks and that was when staff awakened her/him at 10:30 p.m. on Saturday. Resident #6 stated the staff informed her/him that a shower needed to be done at this time because they needed to get the showers caught up [behind]. The resident stated normally received showers after the supper meal. 2. Resident #7 had a MDS assessment with a reference date of 12/30/16. The MDS identified the resident had diagnosis which included diabetes, asthma and chronic kidney disease. The MDS indicated the resident had a BIMS score of 15. A score of 15 represented the resident had no cognitive impairment. The MDS identified the resident depended upon staff for bathing needs. The care plan initiated a problem with activities of daily living self-care performance deficit on 4/13/16 and revised on 1/25/17. The intervention directed staff the resident required extensive assistance of 1 staff member with showering twice a week and as necessary. The shower records indicated the resident had 1 shower since 1/11/17 and that date to be on 1/22/17. During an interview on 1/26/17 at 1:55 p.m., Resident #7 stated she/he had a shower the other day but prior to that it had been 2 and ½ weeks without a shower. Resident #7 stated she/he could count on [expect] a shower if Staff B, certified nursing assistant (CNA), was assigned to care for him/her. 3. Resident #4 had a MDS assessment with a	F 312	Please See attached	3-1-17

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F 312	Continued From page 29 reference date of 1/1/17.revealed Resident #4 had diagnoses that included diabetes, depression, chronic pain and other mental disorder due to a known physiological condition. The BIMS test identified a score of 14. A score of 14 identified no cognitive problems. The MDS indicated the resident required physical help with part of the bathing activity. The shower records revealed the resident had 1 shower since 1/11/17 and that date was on 1/21/17. During an interview on 1/24/17 at 1:10 p.m. Resident #4 stated he/she had a shower a few days before, and thought close to 2 weeks had passed since the previous shower. 4. Resident #2 had a MDS with a reference date of 1/19/17. The MDS identified the resident had diagnoses that included hip fracture and non-Alzheimer's dementia, symptoms of delirium present with cognitive deficits. The MDS indicated the resident required extensive assistance by 2 or more staff members for transfers to and from bed and chair and required physical assistance with bathing. The care plan, initiated on 12/30/15 and revised on 1/19/16 identified a focus area of activities of daily living self-care performance deficits due to a history of a CVA (stroke). The interventions directed the staff the resident required extensive assistance by 1-2 staff members with showering once a week and as necessary. The interventions directed the staff to give baths on Tuesday and Friday evenings.	F 312	Please see attached 3-1-17	

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F 312	Continued From page 30 The shower records reviewed on 1/24/17 identified the resident had not had a bath or shower since before 1/11/17. Observations of the resident revealed: On 1/24/17 at 9:05 a.m., the resident had a dried flaking powder residue food substance on the right side of the neck near the clavicle area, approximately 6 to 8 centimeters wide and black residue in the wrinkles/folds of the neck. Observation identified the resident had not had a bath or shower for several days if not longer. On 1/25/17 at 10:20 a.m., the resident continued to have dried white flaking powder residue on the right side of the neck without change, black colored residue in the wrinkles/folds of the neck, and ear canals, lower external ears filled with brown ear wax. On 1/25/17 at 5:50 p.m., the Interim Director of Nursing (DON) was directed to assess the resident's hygiene and determine when the resident had last received a bath or shower. During an interview on 1/26/17 at 3:55 p.m., the Interim DON stated the resident had received a thorough bed bath last evening and could not say when the resident was last bathed prior to then. The DON confirmed the resident had poor body hygiene and needed to be bathed. On 1/24/17 at 2:15 p.m. a small group of residents (4 residents) were interviewed. The residents stated the facility had been short staffed, during the previous 2 weeks. The residents voiced there were only 2 CNA's in the building on the 2:00 p.m. to 10:00 p.m. shift, on at	F 312	Please see Attached 3-1-17	

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F 312	Continued From page 31 least 2 different days. One resident stated he/she had not had a shower for 9 days; another resident stated it had been over 2 weeks since their last shower, 1 resident stated if it wasn't for the Hospice staff he/she probably wouldn't get a shower, and the 4th resident stated they used to get 2 showers a week and now only receive 1 per week, but uncertain when had the last shower. Staff interviews: On 1/24/17 at 7:20 a.m., Staff E, CNA, stated the CNA assigned to the hall is responsible for showers on that hall, and staff fill out a skin sheet for every shower and put the sheet in the shower book. On 1/24/17 at 7:38 a.m., Staff D, CNA, stated each hall has a book with the assigned showers/shower schedule, and the CNA assigned to the hall is responsible for the showers scheduled on that day. On 1/26/17 at 8:45 a.m., Staff I, CNA, stated the CNA's were instructed for the last couple of weeks that they had to have their showers done before they could leave. She stated there frequently are only 3 CNA's scheduled for the day shift (6:00 a.m. to 2:00 p.m.) and to be honest, it was not possible to get them all done, some had to be skipped. On 1/24/17 at 4:00 p.m., the Administrator stated she was unaware of residents not having baths or showers for 9 or more days. The interim DON, present at the time, stated on 1/15/17, she directed staff to complete a skin sheet when they performed a shower and place the sheet in a 3 ring binder at the front nurse's station. When	F 312	Please see attached 3-1-17	

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F 312	Continued From page 32 advised that the shower sheets were reviewed on that date and several residents had not received a bath or shower for nearly 2 weeks and longer, the Interim DON stated she planned to use another staffing agency with a goal of better staff coverage.	F 312		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews, the facility failed to	F 323	Please see attached 3-1-17	

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F 323	Continued From page 33 ensure the resident environment remained as free from accident hazards as possible and failed to provide adequate supervision to ensure each resident's safety for 1 of 12 residents reviewed (Resident #11). The facility reported a census of 60 residents. Findings include: The 12/3/16 Minimum Data Set (MDS) assessment tool revealed Resident #11 had diagnoses that included seizure disorder, post traumatic stress disorder, alcohol abuse and manic depression, had intact memory without symptoms of delirium, and independent for ambulation, dressing, toileting and bathing. The nursing care plan included a problem identified as elopement risk, initiated on 8/7/16, with 1/19/17 goal the resident would not leave the facility unattended, and interventions that included door codes at entrances. Nurse's Notes revealed the following entries: 10/16/16 at 10:30 p.m. - resident suspected of smoking in room, staff entered the room, smelled of smoke, resident denied that he/she had smoked or had cigarettes and became aggressive towards staff. Police called to the facility for staff safety. 10/26/16 a 4:43 p.m. - the director of nursing (DON) notified the facility social worker the resident had smoked and consumed alcohol in his/her room on the previous weekend and asked the employee to address the topics with the resident. The discussion was met with denial and belligerent responses from the resident.	F 323	Please see attached 3-1-17	

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F 323	Continued From page 34 11/12/16 at 11:29 a.m. - smelled smoke in the hall by the resident's room, staff entered the room, searched for cigarettes and lighter, resident became physically aggressive towards staff and the police called to the facility. 11/12/16 at 2:31 p.m. - resident became belligerent towards staff and refused to hand over his/her cigarettes when staff reminded him/her that it was illegal to smoke in the facility and staff would contact police. During an interview on 1/26/17 at 12:50 p.m., the resident stated he/she was getting kicked out of the facility, he/she was free to come and go as they pleased and didn't need to be in a nursing home, and looked forward to his/her own place where he/she could smoke. During an interview on 1/25/17 at 4:55 a.m., Staff F, Licensed Practical Nurse (LPN), stated she smelled cigarette smoke around the resident's room, she entered the room with Staff G, Certified Nursing Assistant (CNA), found the window open with screen pushed out as the resident held his/her arm held out the window with a lit cigarette. The resident denied the activity and became physically aggressive towards staff when they attempted to search the room. The staff reported a cigarette carton with multiple cigarette butts and a lighter found in the room. During an interview on 1/26/17 at 8:45 a.m., Staff I, CNA, stated she has smelled cigarette smoke from the resident's room, entered the room and found a haze of cigarette smoke and the resident denied that he/she smoked in the room. The staff	F 323	Please see attached 3-1-17	

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F 323	Continued From page 35 reported that she told the nurse and did not confront the resident. During an interview on 1/26/17 at 6:00 a.m., Staff M, CNA, stated there was 1 night on the night shift when staff had to perform 15 minute checks because the resident was very intoxicated, but otherwise the resident was independent without staff interaction, often in the room with the door shut and staff unaware that he/she smoked in the room unless they smelt it in the hallway. During an interview on 1/26/17 at 3:30 p.m., Staff A, LPN, stated there were no routine checks of the resident, staff would smell cigarette smoke and have to check the resident's room and tell him/her to stop, the resident knew he/she was not supposed to smoke in their room but that didn't stop the resident. During an interview on 1/25/17 at 1:18 p.m., the interim Director of Nursing (DON) stated it was a smoke-free facility and resident's could smoke outside at a designated location. When asked what she expected staff to do if the resident smoked in the facility the DON stated they should phone the manager or supervisor on call, and not certain if the staff had received those directives. During an interview on 1/19/17 at 1:24 p.m., the Administrator stated the resident smoke and drank at the facility despite instructions that it was not permitted, the facility had tried and could not discharge the resident as other facilities declined their requests for his/her transfer. When asked how the resident acquired the cigarettes and alcohol, the Administrator responded the resident was free to come and go from the facility as he/she was independent.	F 323	Please see attached 3-1-17	

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F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) 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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill	F 353	Please see attached 3-1-17	

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F 353	Continued From page 37 sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff member interviews, the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility reported a census of 60 residents. Findings include: The 12/13/16 Resident Council meeting Minutes revealed the residents voiced concerns again about lack of staff, unable to find a Certified Nursing Assistant (CNA) when needed, and long waits for answered call lights. The Director of Nursing (DON) went over staffing on the identified problem days and verified the facility was fully staffed and stated she would address the matter and direct the CNAs to answer call lights promptly. During a resident group interview conducted on 1/24/17 at 2:15 p.m., 3 of the 4 residents dependent on staff for care and assistance stated they wait 30 minutes or longer for staff response to their call lights, it happened daily and on all shifts unless "the State" was in the building. One of the residents stated it once took 3 and 1/2	F 353	Please see attached 3-1-17	

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F 353	Continued From page 38 hours for staff to respond to their call light in the afternoon. The residents stated they had discussed their concerns with the previous DON and were told the facility had ads in the paper for open positions and couldn't get anyone to work there. During an interview on 1/24/17 at 1:10 p.m., Resident #4 stated he/she waited 20 to 30 minutes or longer for staff response to call lights at least 4 or 5 times every weekend and 2 or 3 times during the week and happened on all shifts. During an interview on 1/26/17 at 1:55 p.m., Resident #7 stated staff response to call lights took 45 minutes to an hour nearly daily and especially on the evening shift. During an interview on 1/18/17 at 5:30 a.m., Staff G, CNA, stated there usually was not enough staff on the night shift (10:00 p.m. to 6:00 a.m.), she was the only CNA in the building with 1 other CNA assigned in the Memory Care Unit a month ago, she spoke to the DON about the shortage, DON said it wouldn't happen again, but has worked with 2 other CNAs since then with 1 of the 2 assigned to the unit, and only 1 nurse on the night shift. During an interview on 1/26/17 at 8:45 a.m., Staff I, CNA, stated for the last couple of months, Staff H, unit manager and the DON had directed the night shift CNAs when they performed last rounds they were to fully dress the residents but leave them in bed, as the day shift was short staffed. During an interview on 1/24/17 at 4:00 p.m., the interim DON stated the facility was going to start using another staffing agency as they could not	F 353	Please see attached 3-1-17	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 39 rely on the current staffing agency to meet the facility's staffing needs.	F 353		
F 362 SS=F	483.60(a)(3)(b) SUFFICIENT DIETARY SUPPORT PERSONNEL (a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. (b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff member interviews, the facility failed to employ sufficient dietary staff and provide staff supervision that ensured the functions and responsibilities of the food and nutrition services were carried out. The facility reported a census of 60 residents. Findings include: Observation on 1/17/17 at 7:01 p.m. revealed Staff Q Dietary Aide (DA) hired 7/25/12, as he operated the dishwasher and could not identify how the low-temperature dishwasher sanitation properties were tested or where logs with such information were located. Staff O, DA, hired 12/23/16, cleared and sanitized tables in the dining room as Staff R, cook, hired 12/30/16, stated this was one of the first nights that he had cooked on his own, had placed left-over chicken potpie soup served at supper in a container approximately 8 inches high, 8 inches across and deep, the container nearly full and covered with	F 362	Please see attached 3-1-17	

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F 362	Continued From page 40 lid, with recorded temperature of 162 degrees Fahrenheit (F) at that time and placed in the walk-in cooler with temperature of 40 degrees F. Staff R could not identify when food temperatures were recorded or where the information was located. Documents available in the kitchen at that time revealed food temperatures were not recorded at each meal or daily. Staff R could not identify or describe temperature requirements when left-over food was refrigerated for re-use and stated he had not been educated to record temperatures. Observation in the walk-in cooler on 1/17/17 at 8:21 p.m. with Staff R revealed the facility did not have any eggs, egg products or ham, and approximately 40 biscuits. A breakfast sandwich was the entree on the 1/18/17 planned breakfast menu, composed of a biscuit, ham, cooked egg and cheese. During an interview at that time, the Administrator was not aware that the items required for the planned breakfast were not in the building, and she would contact the facility's previous contracted Registered and Licensed dietician (RD/LD). Observation in the facility kitchen on 1/18/17 at 7:40 a.m. revealed the scheduled food delivery had just arrived and included 2 boxes of liquid eggs (used for scrambled eggs) but did not include fresh eggs. Observation in the facility kitchen on 1/18/17 at 11:39 a.m. revealed: 1. Staff P, Dietary Supervisor, attempted a temperature reading from the meatloaf with a thermometer that wasn't operational. 2. Staff T, DA, hired 7/18/16, Staff Z, DA, hired	F 362	Please see attached 3-1-17	

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F 362	Continued From page 41 10/24/16, Staff R and Staff P, all in the kitchen at the time, did not know how to calibrate the thermometers in the kitchen or obtain an accurate temperature recording with the equipment they had in the kitchen. An employee listing report revealed dietary staff also included Staff AA, DA, hired 6/26/16, Staff V, DA, hired 8/8/16, Staff S, DA, hired 1/11/17, Staff X, DA, hired 10/24/16 and Staff U, DA, hired 7/28/16. A 1/19/17 request for documentation of the dietary employees food sanitation safety education, required for dietary employees, revealed Staff T and Staff U were the only employees that had the education. During an interview on 1/17/17 at 7:40 p.m., the Administrator stated the previous dietary manager had walked out 2 weeks earlier, and a new dietary manager, Staff P, hired 1/5/17. During an interview on 1/18/17 at 7:57 a.m., the facility's previous RD/LD stated she received a phone call around 9:00 p.m. the evening before when she was informed the breakfast menu items were not in the building and directed staff to purchase eggs, boil them, and serve boiled eggs, oatmeal and toast for breakfast on 1/18/17. During an interview on 1/18/17 at 11:40 a.m., Staff P stated the meatloaf was prepared according to the recipe that morning, the hamburger was frozen, didn't thaw when the running water method used to thaw the meat so she broke the meat into pieces, dropped in a pan of boiling water and thawed the meat that way. When asked at that time who directed that she stated that she didn't consult with anyone prior to the action taken.	F 362	Please See Attached 3-1-17	

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F 362	Continued From page 42 During an interview on 1/24/17 at 725 a.m., the Administrator stated Staff P quit on 1/20/17, and Staff BB, the maintenance man, had worked as the Dietary Supervisor before and she reassigned him to the position. During an interview on 1/24/17 at 7:58 a.m., the facility's RD/LD, stated his first day at the facility was on 1/17/17, only in the building for approximately 1 hour, the kitchen was very dirty and directed Staff P to start cleaning at that time. The RD/LD could not locate completed kitchen cleaning schedules or temperature logs commonly used with planned menus and stated he would provide forms that the facility could put in immediate use.	F 362	Please see Attached	3-1-17
F 367 SS=D	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews, the facility failed to provide a therapeutic diet as prescribed by the physician for 1 of 1 residents receiving dialysis services outside of the facility (Resident #7). The facility reported a census of 60 residents.	F 367		

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F 367	Continued From page 43 Findings include: 1. Resident #7 had a MDS (Minimum Data Set) assessment with a reference date of 12/30/16. The MDS identified the resident as admitted to the facility on 3/22/16 with diagnoses that included hypertension (high blood pressure), diabetes, asthma (breathing disorder) and chronic kidney disease with dialysis required. The MDS indicated the resident had a BIMS (Brief Interview for Mental Status score of 15. A score of 15 reflected the resident did not have cognitive deficits. The MDS indicated the resident required extensive assistance of 2 or more staff members for transfers to and from the bed and chair, dressing, bathing, toileting and personal hygiene. The physician current recertification orders, directed staff to serve a general renal diet. The current care plan and initiated on admission (3/9/16) included an End-Stage Renal Disease (ESRD) and on dialysis (process to remove toxins from the blood) with interventions that included the following: 1. Provide double portions of protein at meals, encourage lower sodium selection. 2. Provide no added salt (NAS), low potassium diet with 1500 milliliter (ml) fluid restriction (approximate 50 ounces). A progress note transcribed by the facility's Registered and Licensed Dietician (RD/LD) on 12/31/16 directed the following: NAS (no added salt), low potassium diet with 1500 milliliter fluid restriction. Communication from the dialysis RD/LD revealed the resident tells her that he/she	F 367	Please see attached 3-1-17	

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F 367	Continued From page 44 is hungry. The resident weighed 264.8 pounds, a 17 pound gain in 6 months. Skin concern identified on left buttocks and double portions of meat/protein at all meals recommended. During an interview on 1/26/17 at 1:55 p.m., the resident stated he/she went to dialysis at 5:00 a.m. on Monday, Wednesday and Friday. The resident stated the facility's dietary department did not provide a breakfast meal and staff served whatever food they could locate in the facility, sometimes the employee's food, and served a bowl of cold cereal and Oreo cookies for breakfast the day of dialysis. The resident voiced she/he would like a hot breakfast before going to dialysis. Staff interviews revealed: On 1/25/17 at 4:55 a.m., Staff F, Licensed Practical Nurse (LPN), stated the resident transported to dialysis at 5:00 a.m. on Monday, Wednesday and Friday when the facility's dietary department was closed, staff did not have access to it on the night shift and forced to locate whatever food they could find in the facility in order to provide breakfast prior to the resident's departure. Staff F stated today the resident received a bowl of Fruity Pebbles cereal and graham crackers for breakfast. On 1/26/17 at 2:45 p.m., Staff B, Certified Nursing Assistant (CNA) stated staff often bought boxes of cereal and brought them to the facility so the resident could have breakfast before dialysis as the kitchen was closed at that time. During an interview on 1/26/17 at 3:40 p.m., Staff A, LPN, stated the dietary department did not	F 367	Please See Attached 3-1-17	

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F 367	Continued From page 45 provide the resident's breakfast on dialysis days. The staff would look throughout the facility in order to find food, sometimes a sandwich or food from vending machines for the resident's breakfast. This had been ongoing since the resident's admission. Staff A stated sometimes the staff would give money to the driver so he could drive through McDonald's [fast food restaurant] so the resident could get a breakfast sandwich. During an interview on 1/26/17 at 4:45 p.m., the facility's newly appointed dietary supervisor stated he would ensure the dietary staff made a nourishing breakfast meal available for the resident prior to dialysis.	F 367	Please see attached 3-1-17	
F 368 SS=E	483.60(f)(1)-(3) FREQUENCY OF MEALS/SNACKS AT BEDTIME (f) Frequency of Meals (f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. (f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. (f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of	F 368		

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

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F 368	Continued From page 46 scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff member interviews, the facility failed to serve meals at scheduled times and failed to provide bedtime snacks. The facility reported a census of 60 residents. Findings include: The facility's posted meal times were 7:00 a.m., 11:30 a.m. and 5:00 p.m. Observations of meal service at the facility revealed: 1/18/17 at 7:36 a.m., the first meal served in the dining room where approximately 30 residents were gathered for breakfast. The Administrator toasted bread on the conveyor toaster in the kitchen. 1/18/17 at 11:39 a.m., no food served to the approximate 35 residents seated in the dining room. Upon entry to the kitchen, staff obtained a temperature of 122.2 degrees Fahrenheit (F) from the meatloaf in the oven, the main entree prepared from scratch that day, with a required minimal 165 degree F cooked temperature. Staff served the first alternate entree at 11:51 a.m., and the first piece of meatloaf served at 12:11 p.m. During a group resident interview conducted 1/24/17, 3 of the 4 residents stated the bedtime snack cart was prepared by the dietary department and distributed by nursing staff 3 or 4	F 368	Please see attached 3-1-17	

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F 368	Continued From page 47 times per week, the cart usually stocked with cookies, chips, and occasional sandwiches and fruit. One of the residents stated he/she was an insulin-dependent diabetic and required a substantial bedtime snack such as a sandwich that wasn't always available on the snack cart. The residents related short nursing staff as the reason snacks were not passed daily. The group also stated meals were seldom served on time, the supper meal regularly served 30 to 45 minutes late and the noon meal often 20 to 30 minutes late, there was constant turnover of dietary staff that included the supervisor, and questioned if the staff had the skills required for food preparation. During an interview on 1/26/17 at 12:56 p.m., the Registered and Licensed dietician (RD/LD) agreed that insulin-dependent diabetics required consistent food items for evening snacks, stated he would educate the dietary staff on appropriate items for the snack cart and would ensure the items were available for distribution. .	F 368	Please see attached 3-1-17	
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 371		

Pearl Valley Rehab - Washington

Facility ID # 165453

601 East Polk Street
Washington, IA 52353
Phone: 319-653-6526

Provider's Plan of Correction for Complaint Survey

Conducted January 26,2017 -February 2, 2017

Response to CMS-2567

F 000: Initial Comments

This plan of correction constitutes our credible allegation of compliance with a date of March 1, 2017.

✓ **F 223 FREE FROM ABUSE/INVOLUNTARY SECLUSION**

Survey findings were shared with all staff the week of February 27, 2017 by the administrator. All staff were educated regarding the concerns about abuse due to resident to resident altercations.

All residents are at risk for resident to resident altercations due to community living situation.

On January 30, 2017 training was conducted by the interim Director of Nursing on resident to resident altercations. Policy and procedure were reviewed and updated as needed. Policy and procedure for abuse and reporting of suspected abuse were reviewed with staff during the in-services and all questions were answered.

All suspected abuse will be reported immediately to management staff. All residents involved in altercation will be assessed immediately by nursing staff. Each situation will be investigated and reported to Department of Inspection and Appeals for further evaluation. This process will be taken to QA monthly for the remainder of the year or more frequently if any issues are identified.

F 225 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

Survey findings were shared with all staff the week of February 27, 2017 by the administrator. All staff were educated regarding the concerns about abuse due to resident to resident altercations.

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All suspected abuse will be reported immediately to management staff. All residents involved in altercation will be assessed immediately by nursing staff. Each situation will be investigated and reported to Department of Inspection and Appeals for further evaluation. This process will be taken to QA monthly for the remainder of the year or more frequently if any issues are identified.

F 242 SELF-DETERMINATION RIGHT TO MAKE CHOICES

Survey findings were shared with nursing department the week of February 27, 2017 by the Administrator. All nursing staff were educated regarding the concerns about bathing in the facility.

All residents are at risk to miss correct bathing schedule if they are dependent on staff for bathing.

On January 30,2017 training was conducted by the interim Director of Nursing on bathing schedules. Policy and procedure for bathing were reviewed with staff during the in-services and all questions were answered.

Random audits of bathing completion will be completed daily for 4 weeks, and weekly for 4 weeks. This audits will be completed by nurse management or designee. Results will be shared in QA meeting. If results are favorable the audits will be reduced to monthly for the remainder of the year.

F 312: ADL Care Provided for Dependent Residents

Survey findings were shared with nursing department the week of February 27, 2017 by the Administrator. All nursing staff were educated regarding the concerns about bathing in the facility.

All residents are at risk to miss correct bathing schedule if they are dependent on staff for bathing.

On January 30,2017 training was conducted by the interim Director of Nursing on bathing schedules. Policy and procedure for bathing were reviewed with staff during the in-services and all questions were answered.

Random audits of bathing completion will be completed daily for 4 weeks, and weekly for 4 weeks. This audits will be completed by nurse management or designee. Results will be shared

In QA meeting. If results are favorable the audits will be reduced to monthly for the remainder of the year.

F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

Survey findings were shared with all department the week of February 27, 2017 by the Administrator. All staff were educated regarding the concerns smoking privileges and policy and procedures.

Residents at risk for accidents if they are not following facility smoking policy and are living in a smoke free building.

New policy and procedure were written the week of January 16, 2017. On January 30,2017 training was conducted by the interim Director of Nursing on bathing schedules. Policy and procedure for resident smoking were reviewed with staff during the in-services and all questions were answered. Staff also asked to sign the new policy for acknowledgment of understanding the policy.

All suspected occurrences of smoking outside of designated smoking areas will be reported to management immediately. Residents will be evaluated for safe smoking practices before they can smoke independently. Each situation of non-compliance will be investigated and reported to Administrator for further evaluation. This process will be taken to QA monthly for the remainder of the year or more frequently if any issues are identified.

F 353 SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS

Survey findings were shared with all department the week of February 27, 2017 by the Administrator. Staff educated regarding staffing expectations and the ability to provide quality care.

Residents at risk for poor quality of care if this standard is not met.

New policy and procedure were written January 16, 2017. The facility has been working on increasing staff, and bringing on multiple staffing agency to ensure that needs are being met always.

Daily schedules and census will be reviewed by Director of Nursing or designee. If there are staffing concerns they will be brought to the team's attention so that a solution can be identified. New scheduler in place who is aware part of their job duties is to work the floor if staff is short.

F 362: Sufficient Dietary Support Personnel

Survey findings were shared with all department the week of February 27, 2017 by the Administrator. All dietary staff have been re-educated on staffing by the Dietary Service Manager or designee. All staff have been re-educated on cleaning by the Dietary Service Manager or designee. All dietary staff have been re-educated on proper food handling by the Dietary Service Manager or designee.

All residents have the potential for poor nutritional standards if staffing needs are not met due to dependence on staff for nutrition.

New cleaning schedule, temperature logs, food temperature logs, sanitation logs have been implemented to assure compliance. Additional staff have been hired, trained and scheduled.

The Dietary Manager, Administrator or designee will conduct random audits weekly for 3 months by QA or designee, to ensure compliance. If results are favorable, audits will decrease to monthly for 3 months. If results are again favorable, audits will be quarterly for the remainder of the year.

F367: Therapeutic Diet Prescribed by Physician

Survey findings were shared with all department the week of February 27, 2017 by the Administrator. Dietary staff have been re-educated by the Dietary Manager and Dietician on therapeutic diets.

All residents have the potential for poor nutritional intake if this standard is not met due to dependence on staff for nutrition.

All residents with the potential to be affected by the current practice have been identified and the following corrective action taken. Dietitian and Dietary Service Manager have audited all and therapeutic diets. A complete review of all diets was completed by the Dietitian on February 23, 2017.

Random audits will be completed weekly for 3 months by QA or designee to ensure proper therapeutic diets are followed. If results are favorable, audits will decrease to monthly for 3 months. If results are again favorable, audits will be quarterly for the remainder of the year.

F368: Frequency of Meals/Snacks at Bedtime

Survey findings were shared with all department the week of February 27, 2017 by the Administrator. Dietary staff have been re-educated on appropriate snacks and snack times.

All residents have the potential for poor nutritional intake if this standard is not met due to dependence on staff for nutrition.

The Dietary Manager or designee has developed a snack log to monitor snack intakes, times, and snacks provided. Dietary Service Manager or designee will monitor snack log daily to assure compliance.

Random audits will be completed weekly for 3 months by QA or designee to ensure proper snacks are provided daily. If results are favorable, audits will decrease to monthly for 3 months. If results are again favorable, audits will be quarterly for the remainder of the year.

F371: Food Procure, Store/Prepare/Serve - Sanitary

Survey findings were shared with all department the week of February 27, 2017 by the Administrator. Dietary staff have been re-educated. This education consisted of the importance of proper food procure, storage, preparation, serving, sanitization and cleaning.

All residents have the potential to be adversely affected if this standard of practice is not met.

The Dietary Manager or designee will monitor all dietary food procedures, sanitation and logs to assure compliance. A cleaning schedule has been created.

Random audits will be completed weekly for 3 months by QA or designee to ensure proper food procure, store, prepare, and served. If results are favorable, audits will decrease to monthly for 3 months. If results are again favorable, audits will be quarterly for the remainder of the year.