	S FUR MEDICARE &	MEDICAID SERVICES				OWR N	0.0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		165453	B. WING				C
	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 02	/02/2017
. Annual of Fi	NOMBER OR SUFFLIER						
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O			01 E POLK ST		
				<u>۱</u>	NASHINGTON, IA 52353		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	ACCOUNTER ON T	LOC IDENTIF THIS INFORMATION	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	112	DAIL
		· · · · · · · · · · · · · · · · · · ·					
			_				
F 000	INITIAL COMMENTS			000			
	Amended on July 13, Correction Date	_2017,					
1.7.0.	Correction Date	$\frac{5-1-1}{7}$					3-1-17
1 V AVI							
	The following deficien						
ו`י או		laints #64501-C, #64703-C,					
71	#65028-C, #65257-C,	#65464-C and Incident					
	#65086-I.				OLOCIAL	,	
· · ·					please De attache		
		Regulations (42CFR), Part			I AN ATTACHE		
	483, Subpart B-C.				Dela		
F 223	483.12(a)(1) FREE FF		F2	223			
SS=D	ABUSE/INVOLUNTAF	RY SECLUSION					
	483.12						[
		right to be free from abuse,					
		tion of resident property,	ł				
		fined in this subpart. This					
	includes but is not limit						
		involuntary seclusion and cal restraint not required to					
	treat the resident's syr	•					
	near me residents sy	mptoms.					
	483.12(a) The facility	must_					
		mental, sexual, or physical					
	abuse, corporal punis						
	seclusion;						
		is not met as evidenced					
	by:				· · ·		
	•	n, record review, resident,					
		ews and review of policy					
		acility failed to ensure that					
	each resident was free	e from abuse (Residents #4					
	and #9) due to alterca	tions with Resident #8 #5.				2	
·	The facility reported a	census of 60 residents.				13	
	Findings include:						
\land							
ABADAROUN	ALL	UPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u>				
//////	A A A A A A A A A A A A A A A A A A A	UFFLIER REPRESENTATIVE'S SIGNATURE	6	1_	TITLE		(X6) DATE
	<u>XXVIA II</u>	XT/N		1	ministrator		03/13/2017
					excused from correcting providing it is determined t		
other safeguard	Is provide sufficient protection	on to the patients. (See instructions.) Exc	ept for nursin	ng ho	mes, the findings stated above are disclosable 90 d	avs	

Any deliciency statement bading with an asterisk (*) denotes a deliciency 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 regulsite to continued program participation.

PRINTED: 07/13/2017 FORM APPROVED OMB NO: 0028 0301

in an second sec

	to rentine bront a c	MEDICAID SERVICES				OWR V	IO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		165453	B, WING			1 0:	C 2/02/2017
	PROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		60	IREET ADDRESS, CITY, STATE, ZIP CODE P1 E POLK ST ASHINGTON, IA 52353	<u> </u>	
(X4) IÐ PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 223	 Resident #9 had a assessment with a rei The MDS identified the including hypertension non-Alzheimer's dema cervical spine (neck a the resident score 15 Interview for Mental S of 15 identified the resi problems. The MDS i experienced no deliriu extensive assistance if for bathing. The care plan identified potential to be verbally dementia. The interve problem, (initiated 10// that included: Analyze key times, triggers and what esca document. Assess resident's u situation, allow time for self and feelings toward. Anew intervention, separate room, was ad Resident #9's Progress identified the following On 12/20/16 at 11:00 a agency licensed practic certified nursing assist resident and room mat their room. As she approximated Resident #8 jus 	MDS (Minimum Data Set) ference date of 10/29/16. e resident had diagnosis in (high blood pressure), entia and fracture of the rea). The MDS indicated of 15 points on the Brief tatus (BIMS) test. A score sident had no cognitive indicated the resident is symptoms and required by 1 or more staff members and the resident had the y aggressive regarding entions related to dementia 21/16), with interventions places, circumstances, alates the behavior and inderstanding of the r the resident to express rds the situation. the resident moved to a idded on 12/21/16. s Notes (nurse's notes) entries: a.m., Staff J, a contracted cal nurse (LPN), stated a iant (CNA) reported this te (Resident #8) yelled in proached the resident's ne out of his/her room and	F	223	Pland what	d	3-1-17

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

If continuation sheet Page 2 of 53

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES					······································	OMB N	<u>O. 0938-039</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		e survey Pleted
		165453	B. WING			C 02/02/20	
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
PEARL V	ALLEY REHABILITATIO	N & HEALTHCARE CENTER O			E POLK ST ISHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 223	resident not to return approximate same ti the room, passed Re- verbal exchange bel- residents were sepa agreed to have lunch 12/20/16 at 11:10 a. assessed the reside the resident stated F neck but not hard er 12/20/16 at 11:30 a. administrator was not the Director of Nursi A signed written stat 11:00 a.m. by Staff J assistant informed h Resident #9 yelling a went to check, Resid choked him/her. Sta resident to stay in th Resident #8 passed exchanged verbal ag stated Resident #9 r not move them back All 3 of Staff J's entri notation "Incorrect D 12:08 p.m. on 12/20 The facility policy an Neglect and Exploita included and directe Each resident has th sexual, physical and	n to the room and at the ime, Resident #8 came out of esident #9 and there was a tween the 2 residents. The 2 arated and Resident #9 h in his/her room. m., Staff J documented she nt's neck, no marks noted, Resident #8 squeezed his/her nough to leave marks. m., Staff J documented the ot in the building at the time, ng was notified of the event. ement dated 12/20/16 at J, documented the musing er of Resident #8 and at each other. When she dent #9 said Resident #8 just aff J stated she directed the e dining room. When by Resident #9, they ggressions. Resident #8 noved the curtains and would is o he/she choked her/him. tes were lined through, with bocumentation" recorded at	F	223	Places and and see	Ud	31-1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/13/2017 FORM APPROVED

•

.....

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB N	IO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		165453	B. WING				С
		100400	D. WING			02	2/02/2017
INAME OF P	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O			301 E POLK ST		
	r <u></u>				NASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	Ε	COMPLETION DATE
	must not be subject to including, but not limit residents, staff of othe resident, or other indiv The Abuse coordinato Administrator, or facilit Report allegations or s immediately to the Adr accordance with state and Certification agen established procedure Abuse means the willfu unreasonable confiner punishment with result mental anguish. Physical abuse include slapping, pinching and Initiate an investigation allegations of abuse. N physician, resident's fa and Medical Director. Obtain witness stateme policies. Contact the State Ager Ombudsman office to r Monitor and document including the response nursing interventions. directed by the policy in A written statement dat Staff E stated she walk	a abuse by anyone, ed to, facility staff, other er agencies serving the viduals. r in the facility is the DON, ty appointed designee. suspected abuse ministrator, other officials in law, and the State Survey cy (lowa DIA) through s. ul infliction of injury, ment, intimidation, or s, but not limited to hitting, kicking. n immediately for lotify the attending smily/legal representative ents, following appropriate hey and the local report the alleged abuse. the resident's condition, to medical treatment or Document actions taken in the resident's record.	F	223		ź	3-1-17
	resident's room, and he	eard both residents yelling					

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

Event ID: 125S11

Facility ID: IA0948

If continuation sheet Page 4 of 53

CENIER	S FOR MEDICARE &	MEDICAID SERVICES			0	<u>MB NO. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(×	3) DATE SURVEY COMPLETED
		165453	B. WING			C 02/02/2017
NAME OF PL	ROVIDER OR SUPPLIER	.1		STREET ADDRESS, CITY, STATE,		02/02/2017
				601 E POLK ST		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O				
		·····		WASHINGTON, IA 52353		- <u></u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	I OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 223	Continued From pag	e 4	F	223		
	and cursing at each o	other [Resident #8, #9].				
	A written statement of the DON and Staff H stated Resident #9 s mate, Resident #8, y other, denied that he both Resident's #8 a Resident #8 wanted #9's dog when it visit	lated 12/20/16 and signed by , registered nurse (RN), aid he/she and their room elled and cursed at each /she had been choked, then nd #9 defended each other, to continue to see Resident ed. The 2 residents argued ad to move from each other's		Plase Del arta	ahad	3-1-1
	Observations through revealed both Resider in the same dining ro	ent's #8 and #9 ate all meals		atto		
	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					
	•	ocumentation of the event or arrived and instructed her				
		low protocol, not to chart it,				1

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

PRINTED: 07/13/2017 FORM APPROVED

-**-** ·

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			······································	OMB N	<u>O. 0938-0391</u>
3	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
*		165453	B. WING				C
	PROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		601	REET ADDRESS, CITY, STATE, ZIP CODE I E POLK ST ASHINGTON, IA 52353	02	2/02/2017
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	yelled at her when sh charted on it, directed (the facility) would tak came to the facility the residents and moved room. During an interview or E, CNA, stated she w way past Resident's # heard them yell at eac the room the argumer heated, she informed During an interview or L, facility owner, state Administrator and Res 12/20/16. Resident # his/her room mate in t Resident #9 denied th him/her. The owner st reviewed security vide not see any such activ occurred. When aske duty at the time of the only spoke to the Adm moved to a larger roor Administrator stated R Resident #8 and the s and the facility had no matter. During an interview or Resident #9 stated his choke him/her about a in their recliner chair, o hands how Resident # this resident's neck, m	e saw that she had already her to strike it out, and they e care of it. The owners e same day, spoke with both this resident to another an 1/18/17 at 2:02 p.m., Staff orked on 12/20/16, on her 8's and #9's room she sho ther, on her return past at continued and was the nurse, Staff J. an 1/18/17 at 3:40 p.m., Staff d he spoke with the sidents #8 and #9 on 8 stated he/she choked he dining room and e room mate had choked ated the Administrator o of the dining room, did 'ity and concluded it had not d if he spoke to the staff on event, the owner stated he inistrator. Resident #9 was in because the esident #9 was jealous of ource of their arguments, t taken other action on the	F	223	Maal Del Attached		3-1-17

•

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

Facility ID: IA0948

If continuation sheet Page 6 of 53

CENTER	S FUR MEDICARE &	MEDICAID SERVICES			<u>OMB NO. 09</u>	20-028
TATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		165453	B. WING _		C 02/02/2	2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
		& HEALTHCARE CENTER O		601 E POLK ST		
FERINE #F				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 ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE CC HE APPROPRIATE	(X5) IMPLETION DATE
F 223	the facility and wante resident. During an interview o	d nothing to do with the on 1/18/17, Resident #9's	F 2	23		
	went to visit and foun different room, spoke who said the resident he/she was not nice to resident told the fami	d about a month ago they ad the resident moved to a to someone in the office t was moved because to the room mate. The ly member that his/her room ske them when they visited		Plaase see a	fached 3	- -1
	Resident #9's respon attorney - POA) state that they moved the r because he/she didn mate, the next time w resident said his/her choke him/her. The seemed happier in th didn't want to take ac	ed the facility notified him/her resident to another room 't get along with the room when he/she visited, the room mate had tried to POA stated the resident he new room and he/she stion on the matter as the nsfer to another facility and				
	of 12/27/16. The MD diagnoses that includ pressure), diabetes, it kidney disease. The identified a score of 7 no cognitive problem delirium present, had others that occurred The MDS revealed th from bed to chair with	a MDS with a reference date DS identified the resident had led hypertension (high blood malnutrition and chronic MDS indicated a BIMS test 13. A score of 13 identified s but did have symptoms of I verbal behaviors directed at 1 to 3 of the previous 7 days. he resident could transfer hout assistance, required of at least 1 staff person for a ambulate				

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

and the second second

and the second second

PRINTED: 07/13/2017 FORM APPROVED OMB NO 0938-0391

· _ _ _ · · ·

and a <u>s</u>an an sa N

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UDENTIFICATION NUMBER:			(X2) MULTIF A. BUILDING		(X3) DATE SURVEY COMPLETED
		165453	B. WING		C 02/02/2017
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E POLK ST WASHINGTON, IA 52353	1 02/02/2017
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	The care plan include verbally aggressive. the staff to do the folic When the resident be- before agitation escal source of distress, en- conversation. If respo walk calmly away and in a written statement stated Resident #8 rep he/she placed Residen main dining room arou During an interview or Resident #8 stated he month but he/she thou jealous of him/her, the mate moved to another that resident at the fact talk to him/her. On 2/2/17, Staff C was stated Resident #8 has striking out and irritab nothing new and just th 3. Resident #4 had a reference date of 1/1/1 resident had diagnose depression, chronic pa disorder due to known The resident scored 14 of 14 reflected the resi impairments.	d a potential for being The interventions directed wing: comes agitated, intervene ates, guide away from gage calmly in nse is aggressive, staff to approach later. dated 12/20/16, the DON ported the resident thought int #9 in a head-lock in the and 11:15 a.m. to 11:30 a.m. 1/18/17 at 4:20 p.m., //she had a room mate last ught the resident was y fought a lot and the room er room, he/she still sees ility but the resident doesn't s interviewed (interim DON) is always had behaviors, le. This behavior was he resident. MDS assessment with a 7. The MDS indicated the is that included diabetes, in and other mental physiological condition. 4 on the BIMS test. A score dent had no cognitive	F 22		3-1-17
	The care plan indicate potential for verbal ago				

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

Facility ID: 1A0948

If continuation sheet Page 8 of 53

	IS FUR MEDICARE &	MEDICAID SERVICES			(<u> 7101 NOT 0838-0381</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C
		165453	B. WING			02/02/2017
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		STREET ADDRESS, CITY, STATE, Z 601 E POLK ST WASHINGTON, IA 52353	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICI	ACTION SHOULD BE	
F 223	interventions directed 1. Monitor behaviors of observed behavior and 2. Psychiatric/Psycho- indicated. Progress Notes (nurse following entry: On 12/5/16 at 4:58 p.r. other resident hit him/ wanted to press charger residents, this resident name and the other re- a purse. Police officer to call the other resider evident, no other action transcribed by the fac The record did not reve assessment or other a alleged abuse, or the shift as directed in the During an interview or Resident #4 stated and his/her room in a whe hit him/her. The resider called the other resider resident often called the wanted the police call he/she talked to the si- police arrived and tolco other resident names.	the staff to: every shift. Document d attempted interventions, geriatric consult as e's notes) included the m Resident reported that ther with a purse and ges. Police interviewed both at called the other resident a esident hit this resident with instructed the resident not ent names. No injuries ons taken. The note was jility social worker. veal documentation of an actions related to the behaviors assessed every e nursing care plan. n 1/24/17 at 1:10 p.m., tother resident wheeled past el chair, swung a purse that of ankle area as they sat in porway of their room, and it ident stated he/she had ent a name, but the other his resident names, he/she ed and charges pressed, ocial worker about it, the him/her not to call the	F 2	Plase All Ato	ched	3-1-17

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

Facility ID: IA0948

If continuation sheet Page 9 of 53

PRINTED: 07/13/2017 FORM APPROVED OMB NO. 0938-0391

and the second second

		I DIONID CENTICEO			OMB NO. 0936-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		165453	B. WING		C
	PROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E POLK ST WASHINGTON, IA 52353	02/02/2017
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETION
F 223	facility social worker (office he heard a corr direction of the reside observe what had occ #4 presented in his of him/her with a purse, and then left. Reside #4 called him/her nam it and swung their pur them. Resident #4 re CNA that said the DO police. The SW notifie spoke with both of the Resident #4 not to cal advised Resident #5 r other actions taken by he looked at Resident mark, the resident sai notify the nurse and h matter with either the During an interview or Staff B, CNA, stated F like each other and of horrible names. Staff day that Resident #5 I but had not witnessed time their exchanges of that she was knew ab During an interview or interim DON stated sh report or investigation resident to resident #5 included hypertension	SW) stated while in his imotion that came from the ourred. After that Resident flice, said Resident #5 hit wanted to call the police int #5 told the SW Resident hes and he/she was tired of se at Resident #4 that hit turned again, pushed by a N said he should call the ed the police, the officer e residents and advised Il Resident #5 names and not to swing their purse, no if the police. The SW said #4's foot and didn't see a d it didn't hurt, so he did not e had not discussed the DON or the administrator. n 1/26/17 at 11:02 a.m., Residents #4 and #5 don't ten called each other B stated she worked the nit Resident #4 with a purse it, and that was the only went beyond name-calling out. n 1/25/17 at 3:05 p.m., the se could not find an incident report on the 12/5/16 tercation.	F 223	Aleand ale attached	3-1-15

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

Facility ID: IA0948

If continuation sheet Page 10 of 53

.

<u> </u>	S FOR MEDICARE &	MEDICAID SERVICES				OWR MC	<u>J. 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		165453	B. WING				02/2017
NAME OF P	ROVIDER OR SUPPLIER	• • • • • • • • • • • • • • • • • • • •	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE		· · · · · · · · · · · · · · · · ·
				6	01 E POLK ST		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		v	VASHINGTON, IA 52353		
(X4) 1D	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	i	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETION DATE
F 223	Continued From page	• 10	F	223			
	out of 15 points possi	ble on the Brief Inventory of					
		cognitive assessment					
	without symptoms of	delirium, verbal behaviors					
	directed at others that	t occurred 1 to 3 of the					
	previous 7 days, and						
		1 staff member for bathing					
		o ambulate and without					
	deficit of any extremit	у.					
	· ·				$\left(\right) \left(\right) \left(\right) \right)$		
	The nursing care plan				AUDE		3-1-17
	problem with interven					-	2-1-17
		sary to protect the rights				(P · ·
	and safety of others (i	ther residents rooms and			Fichto		
	say things to upset the				Million		
		bt to stare in other resident's			Please Del attached		
	rooms (initiated 3/8/16				U O O		
	Progress Notes (nurse following entries:	e's notes) revealed the					
	0- 40/5/40 -1 0-00						
		m. transcribed by Staff H,					
		front of Resident #4's room,					
		ty and swung his/her purse, stop behavior immediately,					
		her had called him/her a					
		nt to go down the hall and					
		e didn't have to. Resident					
	escorted back to his/h						
	On 12/5/16 at 5:03 p.	m. transcribed by the SW -				l	
		d Resident #5 hit him/her				l	
		anted to press charges.				l	
		rviewed both residents and					
	reported the other res	ident called this resident a					
	name and this resider	nt hit the other with their				l	
	purse. Officer instruct	cted the other resident not to				l	
		es. No injury reported, no				l	
	further action taken by	y police.					

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

Facility ID: 1A0948

If continuation sheet Page 11 of 53

 $\frac{1}{2} \left(\frac{1}{2} + \frac{1}{2} \right) = \frac{1}{2} \left(\frac{1}{2} + \frac{1}{2} + \frac{1}{2} \right) \left(\frac{1}{2} + \frac{1}{2} + \frac{1}{2} + \frac{1}{2} \right) \left(\frac{1}{2} + \frac{1}{2} + \frac{1}{2} + \frac{1}{2} \right) \left(\frac{1}{2} + \frac{1}{2} + \frac{1}{2} + \frac{1}{2} \right) \left(\frac{1}{2} + \frac{1}{2} + \frac{1}{2} + \frac{1}{2} \right) \left(\frac{1}{2} + \frac{1}{2} + \frac{1}{2} + \frac{1}{2} + \frac{1}{2} \right) \left(\frac{1}{2} + \frac{1}{2} + \frac{1}{2} + \frac{1}{2} + \frac{1}{2} \right) \left(\frac{1}{2} + \frac{1}{2} + \frac{1}{2} + \frac{1}{2} + \frac{1}{2} + \frac{1}{2} \right) \left(\frac{1}{2} + \frac{1}{2}$

PRINTED: 07/13/2017 FORM APPROVED

	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u>O. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
1		465463					С
		165453	B. WING	1		02	/02/2017
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O		6	01 E POLK ST		
	· · · · · · · · · · · · · · · · · · ·			V	VASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NEMENT OF DEFICIENCIES / 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)	E	(X5) COMPLETION DATE
F 223	Continued From page	11	F	223			
	After further investigat contact with other resi Resident stated he/shi wheelchair or door fran his/her wheel chair ou hall, swung a short ha seated in a wheel chair foot away from the door During an interview on Resident #5 stated Re names, and tired of it. swung the purse at the on their feet when they chair some time before stated the police came swing the purse. The called Resident #4 nar called Resident #4 nar called them names firs The facility policy and in Neglect and Exploitation directed staff to do the Each resident has the sexual, physical and m punishment and involu Residents must not be anyone, including, but other residents, staff or the resident, or other in The Abuse coordinator Administrator, or facility Report allegations or s	me. This resident was in tside of the doorway in the indled purse at Resident #4 ir inside their room and 1 orway. 1/24/17 at 2:25 p.m. sident #4 called him/her Resident #5 stated she/he e resident and struck them y were seated in a wheel e Christmas. Resident #5 e and told him/her not to resident denied he/she mes, unless that resident it. procedure titled Abuse, on policy dated 11/21/12 following: right to be free from verbal, mental abuse, corporal intary seclusion. subject to abuse by not limited to, facility staff, f other agencies serving individuals.			Alase		3-1-17

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

Event ID: 12SS11 Facility ID: 1A0948

If continuation sheet Page 12 of 53

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		104450			С	
NAME OF D	ROVIDER OR SUPPLIER	165453	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	02/02/2017	
		& 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 223	accordance with state and Certification ager established procedure "Abuse" means the w unreasonable confine punishment with resul mental anguish. "Physical Abuse" incl hitting, slapping, pinch Initiate an investigational allegations of abuse. Notify the attending p family/legal represent.	e law, and the State Survey ncy (Iowa DIA) through es. illful infliction of injury, ment, intimidation, or lting physical harm, pain, or udes, but not limited to ning and kicking. on immediately for	F 22:	Please Del attached	3-177:	
F 225 SS=D	Monitor and documer including the response nursing interventions. Document actions tal- the resident's record. 483.12(a)(3)(4)(c)(1)-(ALLEGATIONS/INDIV 483.12(a) The facility	report the alleged abuse. In the resident's condition, to medical treatment or ken directed by the policy in (4) INVESTIGATE/REPORT /IDUALS	F 225			

If continuation sheet Page 13 of 53

PRINTED: 07/13/2017 FORM APPROVED

	COT ON MEDICANE O	VIEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		165453	B. WING		C 02/02/2017
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		STREET ADDRESS, CITY, STATE, ZIP CODE 801 E POLK ST WASHINGTON, IA 52353	1 02/02/2011
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION
	 (i) Have been found g exploitation, misappro- mistreatment by a cou- (ii) Have had a finding nurse aide registry co- exploitation, mistreatm misappropriation of th (iii) Have a disciplinary or her professional lice body as a result of a fi- exploitation, mistreatm misappropriation of re (4) Report to the State licensing authorities and actions by a court of fa- which would indicate unurse aide or other face (c) In response to allege exploitation, or mistreatman misappropriation of response to allege exploitation, or mistreated (1) Ensure that all allege abuse, neglect, exploit including injuries of un- misappropriation of response reported immediately, after the allegation in serious bodily injury, of the events that cause fabuse and do not resu- the administrator of the officials (including to the 	uilty of abuse, neglect, priation of property, or int of law; entered into the State meerning abuse, neglect, nent of residents or eir property; or y action in effect against his ense by a state licensure nding of abuse, neglect, nent of residents or sident property. enurse aide registry or ny knowledge it has of tw against an employee, unfitness for service as a ality staff. gations of abuse, neglect, atment, the facility must: ged violations involving ation or mistreatment, known source and sident property, are but not later than 2 hours made, if the events that volve abuse or result in r not later than 24 hours if the allegation do not involve lt in serious bodily injury, to a facility and to other the State Survey Agency and as where state law provides erm care facilities) in		Rease All All All All All All All All All All	3-177

If continuation sheet Page 14 of 53

CENTER	IS FOR MEDICARE &	MEDICAID SERVICES				OMB NO.	0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		165453	B, WING			C 02/02/2017		
	E OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 601 E POLK ST WASHINGTON, IA 52353		1 0210	212011				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT 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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 225	accordance with State procedures. (2) Have evidence that thoroughly investigate (3) Prevent further po exploitation, or mistre investigation is in prod (4) Report the results administrator or his or representative and to with State law, includi Agency, within 5 work if the alleged violation corrective action musi This REQUIREMENT by: Based on record revi interview and review of the facility failed to no Inspections and Appe resident abuse. The i #9,#8 and Resident # census of 60 resident of 12 residents. Findings include: 1. Resident #9 had a assessment with a ref revealed Resident #9 included hypertension non-Alzheimer's demo	e law through established at all alleged violations are ed. tential abuse, neglect, atment while the gress. of all investigations to the r her designated other officials in accordance ng to the State Survey sing days of the incident, and is verified appropriate t be taken. is not met as evidenced ew, staff and resident of policy and procedures, stify the Iowa Department of als (DIA) of resident to incidents involved Resident 4,#5. The facility reported a s and the sample consisted MDS (Minimum Data Set) ference date of 10/29/16 had diagnoses that in (high blood pressure), entia and fracture (cervical of the spine). The resident erview for Mental Status) fore of 15 identified the	F	225	Haard		3-1-17	

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

Facility ID: IA0948

If continuation sheet Page 15 of 53

PRINTED: 07/13/2017 FORM APPROVED OMB NO 0938-0391

		MEDICAID SERVICES				OMB N	<u>O. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		E SURVEY PLETED
	and the second	165453	B. WING			1	C /02/2017
NAME OF P	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		6	01 E POLK ST		
				N	ASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page	15	F	225			
	verbally aggressive be problem, (initiated 10/, directed the staff to do Analyze key times, pla triggers and what esca document Assess resident's und allow time for the resid feelings towards the si A new intervention ind to a separate room an Resident #9's Progres revealed the following On 12/20/16 at 11:00 a agency licensed practi certified nursing assist resident and room mat their room. As she app room, Resident #9 can stated Resident #8 jus sat in the recliner. Sta return to the room and time, Resident #8 cam Resident #9 and there between the 2 resident separated and Resider in his/her room. 12/20/16 at 11:10 a.m. assessed the resident	aces, circumstances, alates the behavior and erstanding of the situation, lent to express self and ituation. icated the resident moved d added on 12/21/16. s Notes (nurse's notes) entries: a.m., Staff J, a contracted cal nurse (LPN), stated a ant (CNA) reported this le (Resident #8) yelled in			Plase see Attached		3-1-17-
	neck but not hard enou 12/20/16 at 11:30 a.m.	igh to leave marks. , Staff J documented the					
hu	(02.00) Providence Marcelona Obaci						

•

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

EvenI ID: 12SS11

Facility ID: 1A0948

If continuation sheet Page 16 of 53

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			0	MB NO, 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION (?	(X3) DATE SURVEY COMPLETED	
			0.141010			С	
		165453	B. WING	0.70		02/02/2017	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE I E POLK ST		
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O			ASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	administrator was not the director of nursing Review of the Departi facility did not contact Inspections and Appe Resident #9 and Resi A written statement da Staff J stated the CN/ and #9 yelled at each check Resident #9 sa him/her. She directed dining room when Re wheel chair and the 2 aggressions. Residen moved the curtains at "so I choked him/her" administrator twice, c Assessed Resident # identified. Found DO her, she stated she ha help during lunch, tha Started to chart what residents when the ad she notified her of the chart the rest of what to chart until they inve A written statement d Staff E stated she wa resident's room and h cursing at each other A written statement d the DON and Staff H, stated Resident #9 sa mate, Resident #8, ye	in the building at the time, g was notified of the event. ments records, identified the the Iowa Department of eals of an abuse between ident #8. ated 12/20/16 and signed by A informed her Resident's #8 other, when she went to id Resident #8 just choked d the resident to stay in the sident # 8 passed by in a exchanged verbal nt #8 stated Resident #9 nd wouldn't move them back , Paged DON and ouldn't find either. 9's neck, no injuries N in kitchen and notified ad to stay in the kitchen to it was more important. was said between the dministrator came in and e incident. She continued to was said and was told not estigated. ated 12/20/16 and signed by ilked down Hall #2 past the neard them yelling and	F	225	Magada	21-17	

and the second second

an an N

PRINTED: 07/13/2017 FORM APPROVED OMB NO 0938-0391

and a second second

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		165453	B. WING			0	C 2/02/2017
NAME OF PROVIDER OR SUPPLIER PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O				STREET ADDRES 601 E POLK ST WASHINGTON	S, CITY, STATE, ZIP CODE	P	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EAC	ROVIDER'S PLAN OF CORRECT CH CORRECTIVE ACTION SHOL S-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	both Resident's #8 an Resident #8 wanted to #9's dog when it visite but refused to move fr During an interview or J stated on 12/20/16, informed her the resid Staff J went to their ro red and she could tell something had happe he/she did not have the stated his/her room m over to where he/she directed this resident of then Resident #8 cam cursed at each other a Resident #8 told her h Staff J stated she tried and the DON for 30 m then reported the incid Nurse, and Staff K rep DON, in the kitchen at she assessed Resider injuries and started do when the administrato that she needed to foll yelled at her when she charted on it, directed (the facility) would take came to the facility the residents and moved t room. Staff J stated sh facilities and knew tha mandated report to the administrator's actions disrespectful, unprofest	d #9 defended each other, o continue to see Resident ed, the 2 argued all the time rom each other's room. In 1/18/17 at 1:03 p.m., Staff Staff E, an agency CNA, lents yelled at each other, om, Resident #9's face was by how he/she acted that ned and they were upset, neir neck brace on and ate got out of bed, came was and choked them. She but of the room to the hall, e out of the room, the 2 and she separated them. e/she choked Resident #9. I to notify the administrator inutes without success, lent to Staff K, the MDS borted the incident to the the time. Staff J stated nt #9, did not identify any cumentation of the event r arrived and instructed her ow protocol, not to chart it, e saw that she had already her to strike it out, and they e care of it. The owners e same day, spoke with both his resident to another this type of incident was a e lowa DIA, the and comments were assional and upset her, and ement and complaint about	F	225 P	oaal All Addacd	red	3-1-4

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

Facility ID: 1A0948

If continuation sheet Page 18 of 53

	S FOR MEDICARE &						0, 0930-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
							С
		165453	B. WING			01	2/02/2017
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O			STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225	During an interview o E, CNA, stated she w way past Resident's # heard them yell at eac	n 1/18/17 at 2:02 p.m., Staff orked on 12/20/16, on her #8's and #9's room she ch other, on her return past	F	225			
	that day she overhead voice when she was is J and didn't sound like or how she handled th statement and was ca- later that day when th statement was pretty had said. Staff E stat written statement to h During an interview of Resident #9 stated his choke him/her about a in their recliner chair, hands how Resident a this resident's neck, a another room after it h 2. Resident #8 had a reference date of 12/2 the resident had diago hypertension (high blo malnutrition and chron BIMS test scored the of 13 represented no MDS indicated the resident	the nurse, Staff J. Later rd the administrator's loud in the DON's office with Staff e she was happy with Staff J he incident. She wrote a alled in to the DON's office e DON told her that her close to what the resident ed she also provided a er employer. In 1/18/17 at 4:05 p.m., s/her room mate tried to a month ago as he/she sat demonstrated with his/her #8 placed their hands on ind this resident moved to happened. MDS assessment with a 27/16. The MDS identified			plaase See attached		3-1-17
		ed the resident had a verbal with interventions that					

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

Facility ID: 1A0948

If continuation sheet Page 19 of 53

and an N

PRINTED: 07/13/2017 FORM APPROVED OMB NO 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		165453	B. WING		C 02/02/2017
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E POLK ST WASHINGTON, IA 52353	J 020212011
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 225	from source of distres conversation. If respo walk calmly away and In a written statement stated Resident #8 rep placed Resident #9 in dining room around 12 During an interview or Resident #8 stated he month but he/she thou jealous of him/her, the mate moved to anothe that resident at the fact talk to him/her. 3. Resident #4 had a reference date of 1/1/2 resident had diagnose depression, chronic pa disorder due to known The resident scored 14 of 14 reflected the resi impairments. The care plan indicate potential for verbal agg interventions directed 1. Monitor behaviors e observed behavior and 2. Psychiatric/Psychog indicated.	becomes agitated, tion escalates, guide away s, engage calmly in nse is aggressive, staff to approach later. dated 12/20/16, the DON ported he/she thought they a head-lock in the main 1:15 a.m. to 11:30 a.m. 1:15 a.m. to 11:30 a.m. 1:18/17 at 4:20 p.m., //she had a room mate last ught the resident was ey fought a lot and the room er room, he/she still sees still y but the resident doesn't MDS assessment with a 17. The MDS indicated the s that included diabetes, ain and other mental physiological condition. 4 on the BIMS test. A score ident had no cognitive d the resident had a gression problem. The the staff to: very shift. Document d attempted interventions. geriatric consult as	F 22		3-1-17
	Progress Notes (nurse	's notes) included the			

and the second second

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

Facility ID: IA0948

If continuation sheet Page 20 of 53

PRINTED: 07/13/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	AS FOR MEDICARE &	MEDICAID SERVICES					D. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		165453	B. WING			1	C /02/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O			1 E POLK ST		
	r			/	ASHINGTON, IA 52353		T
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETIO DATE
F 225	other resident hit him wanted to press char residents, this resident name and the other resident a purse. Police office to call the other reside evident, no other acti- transcribed by the face The record did not re- assessment or other alleged abuse, or the shift as directed in the During an interview of Resident #4 stated an his/her room in a whe hit him/her on their for a wheel chair in the d hurt him/her. The resident called the other resider resident often called the wanted the police call he/she talked to the se police arrived and tol- other resident names During an interview of facility social worker of office he heard a com direction of the resider observe what had occ #4 presented in his of him/her with a purse, and then left. Resider #4 called him/her names	- Resident reported that /her with a purse and ges. Police interviewed both int called the other resident a esident hit this resident with r instructed the resident not ent names. No injuries ons taken. The note was cility social worker. veal documentation of an actions related to the behaviors assessed every e nursing care plan. in 1/24/17 at 1:10 p.m., nother resident wheeled past eel chair, swung a purse that isident stated he/she had ent a name, but the other this resident names, he/she led and charges pressed, social worker about it, the d him/her not to call the s. in 1/26/17 at 10:44 a.m., the (SW) stated while in his motion that came from the	F	225	Manda		3-1-1

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

Facility ID: IA0948

If continuation sheet Page 21 of 53

_____%

÷.

					UMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		165453	B. WING		C 02/02/2017
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 225	them. Resident #4 re CNA that said the DO police. The SW notifies spoke with both of the Resident #4 not to call advised Resident #5 r other actions taken by he looked at Resident said notify the nurse and h matter with either the During an interview or Staff B, CNA, stated F like each other and off horrible names. Staff day that Resident #5 r but had not witnessed time their exchanges with that she was knew about the state of the During an interview or interim DON stated shore revealed Resident #5 included hypertension wound infection and m out of 15 points possib Mental Status (BIMS) without symptoms of d directed at others that previous 7 days, and r	turned again, pushed by a N said he should call the ed the police, the officer residents and advised I Resident #5 names and not to swing their purse, no the police. The SW said #4's foot and didn't see a d it didn't hurt, so he did not e had not discussed the DON or the administrator. 1/26/17 at 11:02 a.m., tesidents #4 and #5 don't een called each other B stated she worked the nit Resident #4 with a purse it, and that was the only went beyond name-calling but. 1/25/17 at 3:05 p.m., the e could not find an incident report on the 12/5/16 ercation. ent tool dated 12/9/16 had diagnoses that (high blood pressure), norbid obesity, scored 15 ble on the Brief Inventory of cognitive assessment ellrium, verbal behaviors occurred 1 to 3 of the equired extensive I staff member for bathing ambulate and without	F 22	5 Alase See Walker	3-1-17

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

Facility ID: 1A0948

If continuation sheet Page 22 of 53

PRINTED: 07/13/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		E CONSTRUCTION	T	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
		465452	R MING				C
NAME OF P	ROVIDER OR SUPPLIER	165453	B. WING	-	STREET ADDRESS, CITY, STATE, ZIP CODE	02	/02/2017
				1	01 E POLK ST		
PEAKLVA		& HEALTHCARE CENTER O		<u> </u>	VASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page	e 22	F	225			
	and safety of others (2. Is known to go to o say things to upset th 3. Remind resident no rooms (initiated 3/8/14 Progress Notes (nurs following entries: On 12/5/16 at 3:30 p. RN - Resident was in screamed an obsceni instructed resident to resident stated the oth name, directed resider resident stated the oth name, directed resider resident stated he/sho escorted back to his/f On 12/5/16 at 5:03 p. Other resident reported with their purse and w Police contacted, inter reported the other resident name and this resident purse. Officer instru- call this resident nam further action taken b On 12/6/16 at 3:04 p. After further investiga contact with other resident stated he/sho wheelchair or door fra his/her wheel chair of	ntions that included: ssary to protect the rights initiated 1/2/16). other residents rooms and sem (initiated 4/22/16). ot to stare in other resident's 6). e's notes) revealed the m. transcribed by Staff H, front of Resident #4's room, fity and swung his/her purse, stop behavior immediately, her had called him/her a ent to go down the hall and e didn't have to. Resident her room. m. transcribed by the SW - ed Resident #5 hit him/her vanted to press charges. erviewed both residents and sident called this resident a nt hit the other with their cted the other resident not to nes. No injury reported, no			Please Sel Whached		3-1-17

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

Facility ID: 1A0948

If continuation sheet Page 23 of 53

PRINTED: 07/13/2017 FORM APPROVED OMB NO 0938-0391

o ala N

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C
		165453	8. WING		02/02/2017
	NAME OF PROVIDER OR SUPPLIER PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O		STF 601 WA		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 225	seated in a wheel cha foot away from the do During an interview of Resident #5 stated Re names, and tired of it swung the purse at th on their feet when the chair some time befor stated the police cam swing the purse. The called Resident #4 na called them names fir The facility's Abuse, N policy dated 11/21/12 1. Each resident has t verbal, sexual, physic corporal punishment a Residents must not be anyone, including, but other residents, staff of the resident, or other 2. The Abuse coordina DON, Administrator, of designee. Report alles immediately to the Ad accordance with state and Certification agen established procedure 3. "Abuse" means the unreasonable confine punishment with resul mental anguish.	ir inside their room and 1 forway. In 1/24/17 at 2:25 p.m. esident #4 called him/her are resident #5 stated she/he e resident and struck them y were seated in a wheel e Christmas. Resident #5 e and told him/her not to resident denied he/she mes, unless that resident st. In the right to be free from al and mental abuse, and involuntary seclusion. a subject to abuse by not limited to, facility staff, of other agencies serving ndividuals. ator in the facility is the r facility appointed gations or suspected abuse ministrator, other officials in law, and the State Survey cy (lowa DIA) through is. willful infliction of injury, ment, intimidation, or ting physical harm, pain, or cludes, but not limited to ing and kicking.	F 225	Mease All All All All All All All All All All	3-1-17

٠

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

Facility ID: IA0946

If continuation sheet Page 24 of 53

	[T		
F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE SURVEY COMPLETED
	165453	B. WING		C 02/02/2017
IOVIDER OR SUPPLIER	& HEALTHCARE CENTER O		STREET ADDRESS, CITY, STATE, ZIP COI 601 E POLK ST WASHINGTON, IA 52353	DE
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
allegations of abuse. 6. Notify the attending family/legal represent 7. Obtain witness stat appropriate policies. 8. Contact the State A Ombudsman office to 9. Monitor and docum including the response nursing interventions. 10. Document actions in the resident's recor Review of the DIA rep a.m. determined the fa- incidents involving Re Residents #4 and #5. 483.10(f)(1)-(3) SELF RIGHT TO MAKE CH (f)(1) The resident has schedules (including a health care and provid consistent with his or and plan of care and of of this part. (f)(2) The resident has about aspects of his c are significant to the r (f)(3) The resident has members of the comr community activities t facility. This REQUIREMENT by:	a physician, resident's ative and Medical Director. ements, following agency and the local report the alleged abuse. The the resident's condition, e to medical treatment or a taken directed by the policy d. orts on 2/27/17 at 11:00 acility had not reported the esidents #9 and #8 and -DETERMINATION - OICES is a right to choose activities, sleeping and waking times), ders of health care services her interests, assessments, other applicable provisions is a right to make choices or her life in the facility that resident. is a right to interact with munity and participate in both inside and outside the is not met as evidenced		Please All Atta	z1-17
	F DEFICIENCIES CORRECTION OVIDER OR SUPPLIER LLEY REHABILITATION SUMMARY STI (EACH DEFICIENC' REGULATORY OR I Continued From page allegations of abuse. 6. Notify the attending family/legal represent 7. Obtain witness stat appropriate policies. 8. Contact the State A Ombudsman office to 9. Monitor and docum including the respons nursing interventions. 10. Document actions in the resident's recor Review of the DIA rep a.m. determined the f incidents involving Re Residents #4 and #5. 483.10(f)(1)-(3) SELF RIGHT TO MAKE CH (f)(1) The resident has schedules (including the health care and provid consistent with his or and plan of care and of this part. (f)(2) The resident has about aspects of his care are significant to the r (f)(3) The resident has members of the comr community activities to facility. This REQUIREMENT by:	IDENTIFICATION NUMBER: 165453 OVIDER OR SUPPLIER LLEY REHABILITATION & HEALTHCARE CENTER O SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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 faci	F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI ISSUMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 24 allegations of abuse. ID PREFP TAG Contact the State Agency and the local Ombudsman office to report the alleged abuse. F2 9. Monitor and document the resident's family/legal representative and Medical Director. F2 10. Document actions taken directed by the policy in the resident's condition, including the response to medical treatment or nursing interventions. F2 10. Document actions taken directed by the policy in the resident's record. F2 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. F2 (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. F2 (f)(2) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. F1 (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. F1 (f)(3) The resident has a right to interact wit	PERCIENCIES CORRECTION (x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (x2) MULTIFILE CONSTRUCTION A BUILDING 165453 B. WING CONDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO 601 E POLK ST WASHINGTON, IA 52353 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) In PROVIDER'S PLAN OF CO (CROSS-REFERENCED TO TH DEFICIENCY) Continued From page 24 allegations of abuse. In PROVIDER'S PLAN OF CO (CROSS-REFERENCED TO TH DEFICIENCY) Continued From page 24 allegations of abuse. F 225 Onbudsman office to report the alleged abuse. F 225 Monitor and document the resident's condition, including the response to medical treatment or nursing interventions. F 242 (PACH TO MAKE CHOICES (1) The resident's Pan or reported the incidents involving Residents #9 and #8 and Residents #4 and #5. 483.10((1)(1) (3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES F 242 (1)(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 242 (1)(2) The resident has a right to interest, with members of the community and participate in community activities both inside and outside the facility. F 242 (1)(3) The resident has a right to interact with members of the cornmunity and participate in community activ

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ς.

PRINTED: 07/13/2017 FORM APPROVED

in the second second

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u>OMB N</u>	<u>O. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		e survey Pleted
		165453	B. WING			02	C
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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 SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242	interviews, the facility allow maximum flexib shower (Resident #6) awakened Resident # shower. The facility mesidents and the sam residents and the sam residents. Findings include: 1. Resident #6 had at assessment with a ref The MDS identified th that included hyperter anxiety and depression Interview for Mental S 12 out of 15 points. A moderate cognitive im- indicated the resident assistance of 1 staff memb bathing/showering twi on Tuesday and Satur Shower records revea- shower since 1/11/17, During an interview or Resident #6 stated he in over 2 weeks when p.m. on Saturday, 1/2 they had to have a sh- staff had to get shower	failed to display respect and ility when to receive a . The night shift staff 6 in bed, to receive a eported a census of 60 nple consisted of 12 MDS (Minimum Data Set) rerence date of 11/16/16. e resident had diagnosis asion (high blood pressure), m. The BIMS (Brief tatus) indicated a score of a score of 12 reflected a apairment. The MDS required extensive nember for bathing. d an activity of daily living , with interventions that her assistance for ce weekly and as needed, rday evenings. led the resident had 1 on 1/21/17.	F	242	Pease see atached	Y	3-1-17

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

Facility ID: IA0948

If continuation sheet Page 26 of 53

PRINTED: 07/13/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		165453	8. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	02/02/2017
		& 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 242	During a resident gro stated the facility had the previous 2 weeks nursing assistants (C 2:00 p.m. to 10:00 p.r days. One resident s shower for 9 days, an been over 2 weeks si resident stated if it wa he/she probably woul 4th resident stated the week and now only re uncertain when their I residents agreed that often than the facility Staff interviews revea On 1/25/17 at 4:55 a. practical nurse (LPN) nurse (RN) and unit n shift CNA's to comple the previous weekend resident during the 10 the shower to the resi 1/26/17 at 8:45 a.m., shower schedule for a a binder at the nurse' been instructed for th they have to have the could leave.	up interview, residents been short staffed, during there were only 2 certified NA's) in the building on the m. shift on at least 2 different tated he/she had not had a nother resident stated it had nce their last shower, 1 asn't for the Hospice staff dn't get a shower, and the ey used to get 2 showers a acceive 1 per week, but ast shower was. All they required showers more provided. led: m., Staff F, licensed , stated Staff H, registered hanager, directed the night te Resident #6's shower on d. The staff awakened the) p.m. to 6 a.m. shift to give ident. Staff I, CNA, stated a every resident was located in s station, the CNA's have e last couple of weeks that ir showers done before they	F 24	please sel attachee	2-1-13 L
SS=E	DEPENDENT RESID (a)(2) A resident who activities of daily livin	ENTS			
l					

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

Event ID: 12SS11

Facility ID: IA0948

If continuation sheet Page 27 of 53

PRINTED: 07/13/2017 FORM APPROVED OMB NO: 0938-0391

Ν.

	OF DEFICIENCIES					0936-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPLI	ETED
		165453	B. WING		C 02/0	2/2017
	PROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E POLK ST WASHINGTON, IA 52353		2/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	•	IOULD BE	(X5) COMPLETION DATE
F 312	 personal and oral hyg This REQUIREMENT by: Based on observatio resident and staff interprovide bathing assis hygiene requirements that included Residen residents that particip interview. The facility residents. Findings include: Review of resident bat 1/24/17 identified 30 r bath or shower since residents had only red that time frame. Resident #6 had a assessment with a red The MDS identified th that included hyperter anxiety and depression resident had a Brief fr (BIMS) score of 12 out identified a moderate MDS indicated Reside with bathing. The care plan initiated resident had a deficit self-care due to weak directed one staff pers twice a week and as r Saturday evenings. St 	is not met as evidenced is not met as evidenced n, record review, and rviews, the facility failed to tance at intervals that met is for at least 25 residents it's #2, #4, #6, #7, and 3 of 4 ated in a group resident reported a census of 60 th and shower records on residents had not received a 1/11/17 and an additional 21 ceived 1 bath or shower in Minimum Data Set (MDS) ference date of 11/16/16. e resident had diagnoses nsion (high blood pressure), on. The MDS indicated the nerview of Mental Status at of 15. A score of 12 cognitive impairment. The ent #6 required physical help d on 5/12/16, identified the with activities of daily living ness. The interventions son to shower the resident necessary, Tuesday and shower records identified the 1 shower since 1/11/17	F3	Please See attack	ed	3-1-17

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

Facility ID: IA0948

If continuation sheet Page 28 of 53

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/13/2017
FORM APPROVED
OND NO. 0020 0201

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0.0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		165453	B. WING				C 02/2017
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		S 6	TREET ADDRESS, CITY, STATE, ZIP CODE 01 E POLK ST VASHINGTON, IA 52353	1 027	02/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 312	Continued From page	∋ 28	F	312			
	Resident #6 stated he in over 2 weeks and 1 awakened her/him at Resident #6 stated th a shower needed to b they needed to get th [behind]. The resider showers after the sup 2. Resident #7 had a reference date of 12/3 the resident had diag diabetes, asthma and The MDS indicated th score of 15. A score resident had no cogn	10:30 p.m. on Saturday. e staff informed her/him that be done at this time because e showers caught up at stated normally received oper meal. MDS assessment with a 30/16. The MDS identified			please See attached		3-1-17
	daily living self-care p 4/13/16 and revised of directed staff the resi assistance of 1 staff n twice a week and as	d a problem with activities of performance deficit on on 1/25/17. The intervention dent required extensive member with showering necessary. The shower resident had 1 shower since to be on 1/22/17.					
	Resident #7 stated st other day but prior to weeks without a show						
	3. Resident #4 had a	MDS assessment with a					

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

Facility ID: 1A0948

If continuation sheet Page 29 of 53

PRINTED: 07/13/2017 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					10.0938-0391
1	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION		TE SURVEY MPLETED
		165453	B. WING			0	C 2/02/2017
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O	I	6	TREET ADDRESS, CITY, STATE, ZIP CODE 101 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 TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 312	reference date of 1/1/ had diagnoses that in depression, chronic p disorder due to a know The BIMS test identifi 14 identified no cogni indicated the resident part of the bathing act The shower records n shower since 1/11/17 1/21/17. During an interview of Resident #4 stated he days before, and thou passed since the prev 4. Resident #2 had a of 1/19/17. The MDS diagnoses that include non-Alzheimer's demo present with cognitive indicated the resident assistance by 2 or mo transfers to and from physical assistance w The care plan, initiate on 1/19/16 identified a daily living self-care p history of a CVA (stro- directed the staff the ta assistance by 1-2 sta once a week and as r	 17.revealed Resident #4 cluded diabetes, ain and other mental wn physiological condition. ed a score of 14. A score of tive problems. The MDS required physical help with tivity. evealed the resident had 1 and that date was on n 1/24/17 at 1:10 p.m. e/she had a shower a few ight close to 2 weeks had vious shower. MDS with a reference date identified the resident had entia, symptoms of delirium edeficits. The MDS required extensive ore staff members for bed and chair and required vith bathing. ad on 12/30/15 and revised a focus area of activities of berformance deficits due to a ke). The interventions resident required extensive ff members with showering hecessary. The the staff to give baths on 	F	312	Please Ser attached		3-1-17
FORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID: 12S	S11	Fa	cility ID: 1A0948 If co	ontinuation she	et Page 30 of 53

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

Facility ID: 1A0948

If continuation sheet Page 30 of 53

PRINTED: 07/13/2017 FORM APPROVED OMB NO. 0938-0391

	STON WILDIOANL &	IVIEDICAID SERVICES				1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							0
[165453	B. WING	<u></u>		02/	02/2017
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		6	TREET ADDRESS, CITY, STATE, ZIP CODE D1 E POLK ST JASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 312	The shower records r identified the resident shower since before Observations of the re On 1/24/17 at 9:05 a. flaking powder residur right side of the neck approximately 6 to 8 residue in the wrinkle Observation identified bath or shower for se On 1/25/17 at 10:20 a to have dried white fla- right side of the neck colored residue in the and ear canals, lower brown ear wax. On 1/25/17 at 5:50 p. Nursing (DON) was or resident's hygiene and resident had last record During an interview of Interim DON stated the thorough bed bath last when the resident wa The DON confirmed in hygiene and needed On 1/24/17 at 2:15 p. residents stated the fi- staffed, during the pri- residents voiced ther	reviewed on 1/24/17 t had not had a bath or 1/11/17. esident revealed: 	F	312	plaade See Attached	3	1-17-

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

If continuation sheet Page 31 of 53

.

PRINTED: 07/13/2017 FORM APPROVED OMB NO: 0938 0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED
165453 B. WING	C 02/02/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O 601 E POLK ST WASHINGTON, WASHINGTON,	CITY, STATE, ZIP CODE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH	DVIDER'S PLAN OF CORRECTION (X5) I CORRECTIVE ACTION SHOULD BE COMPLETION REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
F 312 Continued From page 31 F 312 least 2 different days. One resident stated he/she had not had a shower for 9 days; another resident stated in that 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	Al attached 3-1-17

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

Facility ID: IA0948

If continuation sheet Page 32 of 53

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	SURVEY PLETED
		165453	B. WING			C /02/2017
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	that date and several a bath or shower for r the Interim DON state another staffing agene coverage. 483.25(d)(1)(2)(n)(1)- HAZARDS/SUPERVIS (d) Accidents. The facility must ensur (1) The resident envin from accident hazards (2) Each resident rece and assistance device (n) - Bed Rails. The fa appropriate alternative bed rail. If a bed or si must ensure correct ir maintenance of bed ra to the following eleme (1) Assess the resider from bed rails prior to (2) Review the risks a the resident or resider informed consent prio (3) Ensure that the be appropriate for the res This REQUIREMENT by: Based on observation	ver sheets were reviewed on residents had not received hearly 2 weeks and longer, ed she planned to use cy with a goal of better staff (3) FREE OF ACCIDENT SION/DEVICES ure that - comment remains as free as as is possible; and eives adequate supervision as to prevent accidents. accility must attempt to use es prior to installing a side or de rail is used, the facility nstallation, use, and ails, including but not limited ents. th for risk of entrapment installation. th benefits of bed rails with th representative and obtain r to installation. d's dimensions are sident's size and weight. is not met as evidenced	F 31	ploase	3	-1-17

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

Facility ID: IA0948

If continuation sheet Page 33 of 53

PRINTED: 07/13/2017 FORM APPROVED

•

		T				OWR M	<u> </u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					PLETED
		165453	B. WING		1.1.1.1	1	C /02/2017
NAME OF P	ROVIDER OR SUPPLIER			Ş	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
	ALLEY REHABILITATION	& HEALTHCARE CENTER O		6	01 E POLK ST		
		a healindare center o		N	VASHINGTON, IA 52353		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
		· · · · · · · · · · · · · · · · · · ·			DEFICIENCY)		
F 323	Ceptinued From each	- 00	_				
1020		9 33 nvironment remained as		323			
		zards as possible and failed					
	to provide adequate s	supervision to ensure each					
		of 12 residents reviewed					~
		facility reported a census of			\square	7	- +
	60 residents.				please see attached	9	, , ,
	Phanetta and a la la				The of		
	Findings include:				Nel 1		
	The 12/3/16 Minimum	Data Set (MDS)			AT I ACL		
		aled Resident #11 had			Incher		
		ed seizure disorder, post			after		
	traumatic stress disor	der, alcohol abuse and					
		d intact memory without			U		
	symptoms of delirium						
	ambulation, dressing,	toileting and bathing.					
	The nursing care plan	included a problem		ł			
	identified as elopement	nt risk, initiated on 8/7/16,					
	with 1/19/17 goal the	resident would not leave the					
	facility unattended, an	d interventions that					
	included door codes a	at entrances.					
	Nurse's Notes reveale	ed the following entries:					
	10/16/16 at 10:30 p.m	resident suspected of					
		f entered the room, smelled					
	of smoke, resident de						
	smoked or had cigare						
		aff. Police called to the					
	facility for staff safety.			[
	10/26/16 a 4:43 p.m	the director of nursing					
	(DON) notified the fac						
		and consumed alcohol in					
		evious weekend and asked					
	the employee to addre	ess the topics with the		ĺ			
		on was met with denial and					
	belligerent responses	trom the resident.					

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

Facility ID: 1A0948

If continuation sheet Page 34 of 53

PRINTE	D: 0)7/13/	2017
FOR	M Al	PRC	VED
OMB N	0.0	938-()391

<u>CENTER</u>	S FOR MEDICARE &	MEDICAID SERVICES			······	OMB NC) <u>. 0938-039</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165453	B. WING				C 02/02/2017
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PFARI VA	I LEY REHABILITATION	& HEALTHCARE CENTER O		Ì	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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)		(X5) COMPLETIO DATE
F 323	Continued From page	• 34	F	323	8		
	by the resident's room searched for cigarette became physically ag the police called to the 11/12/16 at 2:31 p.m. belligerent towards sta his/her cigarettes whe that it was illegal to sr would contact police. During an interview or resident stated he/she the facility, he/she wa they pleased and didr	- resident became aff and refused to hand over en staff reminded him/her noke in the facility and staff h 1/26/17 at 12:50 p.m., the was getting kicked out of s free to come and go as i't need to be in a nursing ward to his/her own place			please sel attached	(8)	-1-N
	F, Licensed Practical smelled cigarette smo room, she entered the Certified Nursing Assi window open with scr resident held his/her a with a lit cigarette. Th activity and became p towards staff when the room. The staff repor multiple cigarette butt room. During an interview of I, CNA, stated she ha from the resident's room	stant (CNA), found the een pushed out as the arm held out the window us resident denied the shysically aggressive ey attempted to search the ted a cigarette carton with s and a lighter found in the h 1/26/17 at 8:45 a.m., Staff s smelled cigarette smoke om, entered the room and					
		ette smoke and the resident noked in the room. The staff					

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

Facility ID: IA0948

If continuation sheet Page 35 of 53

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/13/2017 FORM APPROVED

OFUL	O FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		165453	B. WING	· · · · · · · · · · · · · · · · · · ·	02/02/2017	
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O	. [STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE COMPLETION	
F 323	reported that she told confront the resident. During an interview o M, CNA, stated there shift when staff had to because the resident otherwise the resident otherwise the resident staff interaction, ofter shut and staff unawar room unless they sme During an interview o A, LPN, stated there the resident, staff wo and have to check the him/her to stop, the re supposed to smoke in stop the resident. During an interview o interim Director of Nu smoke-free facility an outside at a designate what she expected st smoked in the facility phone the manager o certain if the staff had During an interview o Administrator stated to drank at the facility do not permitted, the fac discharge the resident their requests for his/ how the resident acquiral alcohol, the Administrator	the nurse and did not n 1/26/17 at 6:00 a.m., Staff was 1 night on the night o perform 15 minute checks was very intoxicated, but it was independent without n in the room with the door re that he/she smoked in the	F3	23 Mease All Attacher Attacher	3-1-17 d	

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

Facility ID: 1A0946

If continuation sheet Page 36 of 53
PRINTED: 07/13/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE	SURVEY
				-			с
		165453	B. WING		······	02	02/2017
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		6	ITREET ADDRESS, CITY, STATE, ZIP CODE 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 (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 353 SS=E	STAFF PER CARE P 483.35 Nursing Servio		F	353			
	the appropriate comp provide nursing and re- resident safety and at practicable physical, re- well-being of each res- resident assessments and considering the n diagnoses of the facili accordance with the fa at §483.70(e). [As linked to Facility A	etencies and skills sets to elated services to assure tain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care			please sel attached	3	.1-17-
	of personnel on a 24-	each of the following types					
	(i) Except when waive this section, licensed	ed under paragraph (e) of nurses; and					
	(ii) Other nursing pers limited to nurse aides	sonnel, including but not					
	this section, the facilit	aived under paragraph (e) of y must designate a licensed narge nurse on each tour of					
		at ensure that licensed ific competencies and skill					

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

If continuation sheet Page 37 of 53

PRINTED: 07/13/2017 FORM APPROVED OMB NO, 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	D. 0938-039 (SURVEY PLETED
		165453	B. WING	-			C
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		8 6	STREET ADDRESS, CITY, STATE, ZIP CODE 501 E POLK ST WASHINGTON, IA 52353	1 02	/02/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 353	identified through residescribed in the plan (a)(4) Providing care assessing, evaluating resident care plans at needs. This REQUIREMENT by: Based on record revi member interviews, this sufficient nursing staff related services to as attain or maintain the mental, and psychoso resident. The facility residents. Findings include: The 12/13/16 Resident revealed the residents about lack of staff, un Nursing Assistant (Ch waits for answered ca Nursing (DON) went of problem days and versita staffed and stated sho and direct the CNAs to promptly. During a resident groot 1/24/17 at 2:15 p.m., dependent on staff fo they wait 30 minutes to their call lights, it his shifts unless "the Staff	e for residents' needs, as ident assessments, and of care. includes but is not limited to planning and implementing nd responding to resident's is not met as evidenced ew and resident and staff ne facility failed to have f to provide nursing and sure resident safety and highest practicable physical, ocial well-being of each reported a census of 60 ht Council meeting Minutes s voiced concerns again able to find a Certified VA) when needed, and long all lights. The Director of over staffing on the identified rified the facility was fully e would address the matter to answer call lights up interview conducted on	F	353	Plaal Seland Atached	3	-1-17-

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

Event ID: 12SS11

Facility ID: IA0948

If continuation sheet Page 38 of 53

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED C C	
	AND PLAN OF
165453 ^{B. WING} 02/02/201	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O 601 E POLK ST WASHINGTON, IA 52353 WASHINGTON, IA 52353	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DAT	PREFIX
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. F 353 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. MAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA	

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

Facility ID: IA0948

If continuation sheet Page 39 of 53

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:	07/13/2017
FORM/	APPROVED
NID NO	1000 0004

	O FOR MEDICARE &	MEDICAID SERVICES					<u>0. 0938-0391</u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		165453	B. WING			02	C /02/2017
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		601	REET ADDRESS, CITY, STATE, ZIP CODE E POLK ST ASHINGTON, IA 52353	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
F 353	rely on the current sta facility's staffing need	iffing agency to meet the s.		353			10
F 362 SS=F			F	362		3	1-1+
	sufficient support pers effectively carry out the nutrition service. (b) A member of the F staff must participate as required in § 483.2 This REQUIREMENT by: Based on observation resident and staff men failed to employ suffic provide staff supervision functions and response	the functions of the food and Food and Nutrition Services on the interdisciplinary team (1(b)(2)(ii). is not met as evidenced n, record review, and nber interviews, the facility ient dietary staff and ion that ensured the sibilities of the food and e carried out. The facility			Please see attached	-	
	Staff Q Dietary Aide (I operated the dishwas how the low-temperat properties were tested information were loca 12/23/16, cleared and dining room as Staff F stated this was one of cooked on his own, he potpie soup served at approximately 8 inches	I sanitized tables in the R, cook, hired 12/30/16, i the first nights that he had ad placed left-over chicken					

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

Facility ID: IA0948

If continuation sheet Page 40 of 53

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO). 0938-039 ⁻
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY
		165453	B. WING		······		C /02/2017
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		sı	FREET ADDRESS, CITY, STATE, ZIP CODE	1 02	
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O			HEPOLK ST		
 	I		1		ASHINGTON, IA 52353		1
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(XS) CONPLETION DATE
F 362	lid, with recorded tem Fahrenheit (F) at that walk-in cooler with ter Staff R could not iden were recorded or whe located. Documents a that time revealed foor recorded at each mea- identify or describe te when left-over food w and stated he had not temperatures. Observation in the wa 8:21 p.m. with Staff R have any eggs, egg p approximately 40 bisc was the entree on the menu, composed of a and cheese. During a Administrator was not required for the plann building, and she wou previous contracted F dietician (RD/LD). Observation in the fac 7:40 a.m. revealed the had just arrived and in eggs (used for scram include fresh eggs. Observation in the fac 11:39 a.m. revealed: 1. Staff P, Dietary Su	perature of 162 degrees time and placed in the mperature of 40 degrees F. tily when food temperatures are the information was available in the kitchen at do temperatures were not all or daily. Staff R could not mperature requirements as refrigerated for re-use t been educated to record alk-in cooler on 1/17/17 at revealed the facility did not roducts or ham, and suits. A breakfast sandwich a interview at that time, the a aware that the items ed breakfast were not in the add contact the facility's Registered and Licensed cility kitchen on 1/18/17 at e scheduled food delivery notuded 2 boxes of liquid bled eggs) but did not cility kitchen on 1/18/17 at	F	362	Plane	3-	1-1-

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

PRINTED: 07/13/2017 FORM APPROVED OMB NO 0938-0391

	OF DEFICIENCIES					T	<u>J. 0938-0391</u>
1	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
							с
		165453	B. WING			02	/02/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PEARL W	ALLEY REHABILITATION	8 HEALTHCARE CENTER O			601 E POLK ST		
	2111112 DV 07			L	WASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	iX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 362	Continued From page 10/24/16, Staff R and the time, did not know thermometers in the k temperature recording had in the kitchen. An employee listing re also included Staff AA DA, hired 8/8/16, Staff X, DA, hired 10/24/16 7/28/16. A 1/19/17 re the dietary employees education, required for revealed Staff T and S employees that had th During an interview or Administrator stated th manager had walked new dietary manager, During an interview or facility's previous RD/ phone call around 9:0 when she was informe items were not in the purchase eggs, boil th oatmeal and toast for During an interview or Staff P stated the mea according to the recip hamburger was frozer running water method she broke the meat in of boiling water and th	e 41 Staff P, all in the kitchen at y how to calibrate the dichen or obtain an accurate g with the equipment they eport revealed dietary staff A, DA, hired 6/26/16, Staff V, if S, DA, hired 1/11/17, Staff and Staff U, DA, hired quest for documentation of a food sanitation safety or dietary employees, Staff U were the only he education. 1/17/17 at 7:40 p.m., the he previous dietary out 2 weeks earlier, and a Staff P, hired 1/5/17. 1/18/17 at 7:57 a.m., the LD stated she received a 0 p.m. the evening before ed the breakfast menu building and directed staff to pem, and serve boiled eggs, breakfast on 1/18/17. 1/18/17 at 11:40 a.m., atioaf was prepared		362	DEFICIENCY)		1-17-
		ne who directed that she consult with anyone prior to					

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

Facility ID: 1A0948

If continuation sheet Page 42 of 53

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/13/2017 FORM APPROVED OMB NO 0938-0391

		I					0. 0330-0331
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		e survey Pleted
		165453	8. WING			1	С
L	·····	105435	0. 991190			02	/02/2017
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O	- 1	•	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREF TAC	XI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 362	Continued From page	42	F	362			4
F 367 SS=D	Administrator stated S Staff BB, the mainten the Dietary Superviso him to the position. During an interview of facility's RD/LD, state was on 1/17/17, only is approximately 1 hour, and directed Staff P to The RD/LD could not cleaning schedules or commonly used with p he would provide form in immediate use. 483.60(e)(1)(2) THER PRESCRIBED BY PH (e) Therapeutic Diets (e)(1) Therapeutic die the attending physicia (e)(2) The attending p registered or licensed prescribing a resident therapeutic diet, to the law. This REQUIREMENT by: Based on observation resident and staff inter provide a therapeutic physician for 1 of 1 resident	the kitchen was very dirty o start cleaning at that time. locate completed kitchen temperature logs oblanned menus and stated as that the facility could put CAPEUTIC DIET TYSICIAN ts must be prescribed by n. oblysician may delegate to a dietitian the task of s diet, including a e extent allowed by State is not met as evidenced a, record review and rviews, the facility failed to diet as prescribed by the sidents receiving dialysis e facility (Resident #7). The	F	367	please see attached		31-17-

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

Facility ID: IA0948

If continuation sheet Page 43 of 53

PRINTED: 07/13/2017 FORM APPROVED OMB NO 0938-0391

	OT ON MEDICAILE &						7.0830-0381
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
1		165453	B. WING				C
ļ		100400	0.1110	_] 02	/02/2017
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		6	STREET ADDRESS, CITY, STATE, ZIP CODE 301 E POLK ST NASHINGTON, JA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX .	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	COMPLETION DATE
F 367	Continued From page	⇒43	F	367			
	Findings include:						
	assessment with a rel The MDS identified th the facility on 3/22/16 included hypertension diabetes, asthma (bre chronic kidney diseas The MDS indicated th (Brief Interview for Me score of 15 reflected t cognitive deficits. The resident required exter more staff members for	n (high blood pressure), eathing disorder) and e with dialysis required. e resident had a BIMS ental Status score of 15. A he resident did not have			please see attached	3-	1-17-
	The physician current directed staff to serve						
	(3/9/16) included an E (ESRD) and on dialys from the blood) with ir the following: 1. Provide double port encourage lower sodiu	alt (NAS), low potassium r (ml) fluid restriction res).					
	Registered and Licens 12/31/16 directed the salt), low potassium d restriction. Communic	sed Dietician (RD/LD) on following: NAS (no added iet with 1500 milliliter fluid cation from the dialysis esident tells her that he/she					

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

Facility ID: 1A0948

If continuation sheet Page 44 of 53

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/13/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	AS FOR MEDICARE &	MEDICAID SERVICES				<u>OMB N</u>	<u>D. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY PLETED
		165453	B. WING			1	C
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	02	/02/2017
	NOTIOLIC ON SUPPLIEN			1			
PEARL W	ALLEY REHABILITATION	& HEALTHCARE CENTER O		1	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)	IÐ PREF TAG	XIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 367			F	367	7		
	is hungry. The resider	nt weighed 264.8 pounds, a					
	17 pound gain in 6 m						
		cks and double portions of					
	meat/protein at all me	ais recommended.			~ 0	\sim	1-17-
	During an interview or	n 1/26/17 at 1:55 p.m., the			1 OLOG DE	5	
		went to dialysis at 5:00			1 NUU	\mathcal{O}	
		Inesday and Friday. The					
		ility's dietary department			please see attached		
		kfast meal and staff served			P h ld		
		uld locate in the facility,			1 a MACINA		
	bowl of cold cereal an	yee's food, and served a			I A HO		
		alysis. The resident voiced					
		ot breakfast before going to					
	dialysis.	······································					
	Staff Interviews reveal	ed:					
	On 1/25/17 at 4:55 a.r	n., Staff F, Licensed			- -		
	Practical Nurse (LPN)						
		at 5:00 a.m. on Monday,					
		y when the facility's dietary					
		d, staff did not have access					
	to it on the night shift a	uld find in the facility in					
		fast prior to the resident's					
	departure. Staff F star	•					
		ity Pebbles cereal and					
	graham crackers for b						
		n., Staff B, Certified Nursing					
		d staff often bought boxes					
		them to the facility so the					
	the kitchen was closed	eakfast before dialysis as					
·	THE RECEIPTINGS CIUSEL	a a a a ta tunio.					
		1/26/17 at 3:40 p.m., Staff					
	A, LPN, stated the die	lary department did not				[

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

Facility ID: 1A0948

If continuation sheet Page 45 of 53

PRINTED: 07/13/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE	E SURVEY PLETED
		165453	B. WING			C /02/2017
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O	6	NTREET ADDRESS, CITY, STATE, ZIP CODE NOT E POLK ST VASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 367 F 368 SS=E	The staff would look the order to find food, som from vending machine breakfast. This had be resident's admission. the staff would give me could drive through Me restaurant] so the resist sandwich.	breakfast on dialysis days. hroughout the facility in netimes a sandwich or food as for the resident's een ongoing since the Staff A stated sometimes oney to the driver so he cDonald's [fast food dent could get a breakfast n 1/26/17 at 4:45 p.m., the ted dietary supervisor stated lietary staff made a neal available for the ris. DUENCY OF	F 367	Plaal Sebache	9 3	1-17
	must provide at least if times comparable to m community or in accor preferences, requests (f)(2)There must be no between a substantial breakfast the following nourishing snack is se hours may elapse betw meal and breakfast the group agrees to this m (f)(3) Suitable, nourish	ust receive and the facility three meals daily, at regular formal mealtimes in the dance with resident needs, , and plan of care. The more than 14 hours evening meal and g day, except when a erved at bedtime, up to 16 ween a substantial evening e following day if a resident heal span.				

Facility ID: 1A0948

If continuation sheet Page 46 of 53

PRINTED: 07/13/2017 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			COMPLETED		
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		с		
		165453	B. WING			02/	02/2017	
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
		A MEALTHCARE CENTER O			1 E POLK ST			
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		W.	ASHINGTON, IA 52353 PROVIDER'S PLAN OF CORRECTIO	N	(X5)	
(X4) ID PREFIX TAG	IEACH DESICIEN(TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	£	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE	
F 368	Continued From page	ie 46	F	368				
1 000	scheduled meal sen	vice times, consistent with the						
	by: Based on observati resident and staff m failed to serve meal	on, record review, and ember interviews, the facility s at scheduled times and dtime snacks. The facility			please Del Attached	3	1-17	
	Findings include: The facility's posted 11:30 a.m. and 5:00	l meal times were 7:00 a.m.,) p.m.			attached	~		
	Observations of me revealed:	eal service at the facility						
	dining room where	n., the first meal served in the approximately 30 residents breakfast. The Administrator he conveyor toaster in the						
	approximate 35 re room. Upon entry temperature of 12 from the meatloaf prepared from scr minimal 165 degre	m., no food served to the sidents seated in the dining to the kitchen, staff obtained a 2.2 degrees Fahrenheit (F) in the oven, the main entree atch that day, with a required er F cooked temperature. Staff ternate entree at 11:51 a.m., of meatloaf served at 12:11						
	1/24/17, 3 of the	sident interview conducted 4 residents stated the bedtime repared by the dietary distributed by nursing staff 3 or 4						
	department and c 5-2567(02-99) Previous Version		28811		Facility ID: 1A0948	continuation a	sheet Page 47	

PRINTED: 07/13/2017 FORM APPROVED

STATEMEN'	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO. (0938-039
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		165453				
		& HEALTHCARE CENTER O		STREET ADDRESS, CITY, STATE, ZIP COD 601 E POLK ST WASHINGTON, IA 52353	02/02/ E	2017
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORI PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AI DEFICIENCY)		SHOULDEE	(X5) DMPLETION DATE
	insulin-dependent diab insulin-dependent diab substantial bedtime sna that wasn't always avai The residents related si reason snacks were noi also stated meals were the supper meal regular minutes late and the noi minutes late, there was dietary staff that include questioned if the staff ha food preparation. During an interview on 1 Registered and Licensed agreed that insulin-depen- consistent food items for ne would educate the die- tems for the snack cart a tems were available for o	rt usually stocked with casional sandwiches and hts stated he/she was an etic and required a ack such as a sandwich lable on the snack cart. hort nursing staff as the t passed daily. The group seldom served on time, dy served 30 to 45 on meal often 20 to 30 constant turnover of d the supervisor, and ad the skills required for /26/17 at 12:56 p.m., the d dietician (RD/LD) ndent diabetics required evening snacks, stated etary staff on appropriate and would ensure the distribution.	F3	Pland at	ached 31-1	7
SS=F (83.60(i)(1)-(3) FOOD PF TORE/PREPARE/SERV)(1) - Procure food from onsidered satisfactory by uthorities.	E - SANITARY	F 371			
100) This may include food i om local producers, subj nd local laws or regulatio	ect to applicable State				
(ii) fac) This provision does not cilities from using produc	t prohibit or prevent ce grown in facility				

Event ID: 125511

Facility ID: IA0948

If continuation sheet Page 48 of 53

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.

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 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 guarterly for the remainder of the year.

<u>F367: Therapeutic Diet Prescribed by Physician</u>

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.

'n

F368: Frequency of Meals/Snacks at Bedtime

Survey findings were shared with all department the week of February 27, 2017 by the Administrator. Dletary 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 Dielary 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.

https://docs.google.com/document/d/1vd4DUHUnN1c3UtYPnKCO6GrkZUKKwbQ5xgsm4DQcTtY/edit