STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165343	A. BUILDING ______ B. WING ______	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW REHABILITATION CENTER	**601 PARK AVENUE** **SAC CITY, IA 50583**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Amended on November 1, 2017 following the Informal Dispute Resolution decision. Correction date:_______________ The following deficiencies are the result of the recertification survey and investigation of incident #67776-I completed July 5-13, 2017. Incident #67776-I was not substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/01/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165343	A. BUILDING ______ B. WING ______	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW REHABILITATION CENTER	601 PARK AVENUE SAC CITY, IA 50583

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 1 (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on review of personnel records and staff interview, the facility failed to obtain dependent adult and child abuse checks and a criminal background check pursuant to 30 calendar days prior to employment. The sample consisted of 5 personnel files reviewed and the facility reported a census of 50 residents. Findings included: A personnel record for Staff A identified a date of hire as 5/1/17. On 3/23/17, the facility obtained a Single Contact and Background Check (SING) for criminal history and dependent adult abuse, which cleared Staff A, Registered Nurse, to work in the nursing home. A payroll time sheet dated 5/1/17, identified Staff A's first day of employment as 5/1/17. The employment of Staff A did not begin within 30 days of the valid abuse/criminal background check results per 50.7(4). A facility Abuse Prevention, Training and Investigations policy, with a review date of 8/25/16, included direction for a SING	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165343	A. BUILDING ______ B. WING ______	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW REHABILITATION CENTER	**601 PARK AVENUE SAC CITY, IA 50583**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 2 background check to be completed no more than 30 days before the start of employment On 7/11/17 at 1:50 P.M., the facility Administrator was interviewed and confirmed the background checks and abuse history checks should be completed within 30 days of hire.	F 226		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews and review of the policy and procedures, the facility failed to prevent the development of a pressure sore (Resident #10). Upon admission to the facility, Resident #10, entered without a pressure sore and required extensive assistance from staff with activities of daily living. The sample consisted of 3 residents with pressure sores and the facility reported a	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165343	A. BUILDING ______ B. WING ______	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW REHABILITATION CENTER	601 PARK AVENUE SAC CITY, IA 50583

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 3	F 314		

census of 50 residents.

Findings include:

1. Resident #10 had an admission MDS assessment dated 5/31/17. The MDS identified the resident had diagnoses of atrial fibrillation (abnormal heart rhythm), coronary artery disease, hip fracture, intervertebral disc degeneration in the lumbar region and edema (buildup of fluid). The resident scored 13 on the Brief Interview for Mental Status (BIMS). The score of 13 represented the resident had no cognitive problems. The MDS indicated the resident required extensive assistance from 2 staff members for bed mobility, bathing and toileting. The resident required extensive assistance of one staff with transfer and dressing. The MDS documented the resident did not walk in room or the corridor during the assessment period. The MDS identified the resident as not at risk for the development of pressure ulcers and had no pressure ulcers. The MDS identified the facility did not implement a repositioning program.

A Braden Scale For Predicting Pressure Sore Risk form dated 5/24/17 indicated the resident scored 18. A score of 18 indicated the resident at risk for pressure ulcer development. The Braden Scale identified the resident had a problem with moderate to maximum assistance with moving. Complete lifting without sliding against sheets is impossible which can lead to sheer or friction on the skin.

The Review of an admission/readmission nursing assessment dated 5/24/17 revealed no abnormal skin conditions documented upon admission to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165343	A. BUILDING ______ B. WING ______	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW REHABILITATION CENTER	**601 PARK AVENUE SAC CITY, IA 50583**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 4 The Care Plan identified a focus area that the resident needed assistance with activities of daily living related to limited mobility, weakness and the right hip fracture (undated). The intervention included to please check skin for redness, open areas, scratches, cuts, bruises. The Care Plan identified another focus area. The resident has a suspected deep tissue injury ulcer on the right heel and a potential for pressure ulcer development regards to immobility (not dated). The goal for the focus area dated 7/27/17 indicated the pressure ulcer will show signs of healing and remain free from infection. The interventions included to off load the feet when in bed. Use ROHO cushion in wheelchair and a pressure relieving device on the bed and educate the resident the importance of repositioning and how this would help the pressure ulcer heel since prefers not to reposition. Review of an interdisciplinary progress note dated 6/7/17 at 2020 (8:20 PM) identified a staff member called a nurse to the resident's room. The note documented the right heel as red and mushy, but with the skin intact. The resident denied pain or discomfort. The note documented the area as 1.2 by 1.4 centimeters (cm) and blue boots (soft foam boots) initiated. The progress note documented the nurse notified the physician and the son. An interdisciplinary progress note dated 6/8/17 at 1750 (5:50 PM) documented the facility received a facsimile with a physician order for a skin prep (a liquid film forming dressing to prevent friction) to the back of the right heel twice daily until healed.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165343	A. BUILDING ______ B. WING ______	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW REHABILITATION CENTER	601 PARK AVENUE SAC CITY, IA 50583

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 5	F 314		

Review of a weekly pressure ulcer progress report revealed the following information regarding the right heel ulcer identified on 6/7/17:

6/7/17- Right heel measured 1.2 x [by] 1.4 cm with reddened and intact skin. The form failed to stage the wound.
6/13/17- Right heel measured 1.2 x 1.0 cm with no drainage, no odor, and described the heel as a reddened soft deep tissue injury. The report documented the interventions of a Roho cushion (pressure relieving cushion), elevated heels, and a Hormel brand Health supplement.

6/21/17- Right heel measured 1.4 x 1.0 cm with no drainage or odor and described the wound as a flat blister soft deep tissue injury. The report document the interventions as the elevated heels and Hormel brand Health supplement.

6/27/17- Right heel measured 1.4 x 1.0 cm with no drainage or odor. The report documented the blister dried up and left a firm area. The report document the interventions as the elevated heels and Hormel brand Health supplement.

7/3/17- Right heel measured 1.4 x 1.0 cm with no drainage or odor with a brown and dry color. The report document the interventions as the elevated heels and Hormel brand Health supplement.
7/12/17- Right heel measured 1.6 x 1.0 cm with no drainage or odor with a brown and dry firm area.

Review of a medication administration record (MAR) dated 6/1/17-6/30/17 revealed Hormel Plus 2, four ounces twice daily for weight maintenance and protein initiated on 6/5/17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165343	A. BUILDING ______ B. WING ______	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW REHABILITATION CENTER	**601 PARK AVENUE SAC CITY, IA 50583**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 6	F 314		

Continued From page 6

Review of a treatment administration record (TAR) dated 6/1/17-6/30/17 revealed skin prep applied twice daily to the right heel until healed initiated on 6/8/17.

Review of a fax to the physician on 6/23/17 indicated an update on the right heel ulcer and described the ulcer as a flat blister measuring 1.4 x 1.0 cm. The fax listed the current interventions as a supplement, pressure reducing cushion, heels up in bed and used skin prep twice daily.

Review of a fax to the physician dated 6/7/17 indicated a notification of the back of the resident's right heel as red and mushy. The resident denied pain or discomfort. The facility applied blue boots and the area measured 1.2 x 1.4 cm. The physician approved a request to apply skin prep twice daily until healed.

Review of a fax dated 7/12/17 indicated a decline in the right heel ulcer measuring 1.6 x 1.0 cm describing the ulcer as brown, dry and firm. The fax listed the current interventions a supplement, pressure reducing cushion, pressure reducing mattress, heels up in bed, repositioning at least every 2 hours and using skin prep twice daily.

Observation on 7/12/17 at 8:10 AM indicated the resident rested supine in bed with a pillow under his/her calves. Observation identified the resident wore black stockings. Staff B, (licensed practical nurse) removed the resident's stockings and exposed the small hard dark colored callused on the right heel. Staff B applied a skin prep wipe to the callused area, allowed it to dry and then assisted the resident with dressing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165343	A. BUILDING ______ B. WING ______	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW REHABILITATION CENTER	**601 PARK AVENUE SAC CITY, IA 50583**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 7	F 314		

Review of a Pressure Ulcer Risk Assessment and Documentation policy and Procedure updated as January 2011, identified the following:

Residents will be assessed upon admission and re-admission for potential risk factors that may contribute to pressure ulcer development and interventions will be implemented to reduce that risk.

1). The assigned nurse will complete the Admission and Readmission Pressure Ulcer Risk assessment tool on new admission and readmissions.
Determine the factors/conditions that place the resident at risk for developing pressure ulcers.
List any additional risk factors/conditions on page 2 of the form.
Determine interventions in conjunction with each risk factor that has potential to reduce both the likelihood of pressure ulcer development and/or improve the clinical condition of the resident.
Review the risk factors and interventions with the resident and /or responsible party.
Include the signature and date of the nurse who completed the assessment and reviews with the resident at the bottom of page 2.

2). The assigned nurse will complete the Admission Nursing Assessment which includes factors/conditions that may place a resident at risk for pressure ulcer development.

3). Communicate interventions to the appropriate staff.

4). The Admission and Readmission Pressure Ulcer Risk Assessment tool can be used in conjunction with the Resident Status Sheet as a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165343	A. BUILDING ______ B. WING ______	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW REHABILITATION CENTER	**601 PARK AVENUE** **SAC CITY, IA 50583**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 8 partial working care plan until the full care plan is completed per the Resident Assessment Instrument guidelines. 5). Update the care plan and interventions as risk factors change. 6). Preventions: The following interventions, although not inclusive, may be incorporated as deemed pertinent to the resident's condition: -Clean skin gently to minimize the use of force and friction after incontinent episodes. May apply topical barrier agents. -May apply moisturizers to dry skin. -Assist with repositioning immobile residents a minimum of approximately every two hours. -Positioning devices such as pillows or foam wedges may be used to keep bony prominence from direct contact with each other. -Keep head of the head at the lowest degree of elevation consistent with the resident's medical condition and other restrictions. -May use pillows under the calves of the residents who are immobile to relieve pressure on the heels or suspend heels off the foot of the bed. -May use mechanical lifting devices, draw sheets or pads to move residents in bed who cannot assist during transfers and position changes to reduce friction/shearing. -Observe skin when dressing/undressing. -Remove stockings or support stockings to assess skin. -Observe proper placement of tubing to reduce pressure risk. -Assess nutrition and hydration needs quarterly/significant change to maintain skin integrity; encourage foods/fluids. -May use pressure reduction mattress to bed and pressure reduction device to chair.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165343	A. BUILDING ______ B. WING ______	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW REHABILITATION CENTER	601 PARK AVENUE SAC CITY, IA 50583

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 9 -Assist with range of motion for those residents who have mobility deficits. -May utilize physical therapy/occupational therapy services. -The use of excessive layers of linens should be avoided when pressure reduction devices are used on the bed or in a chair. -If appropriate, offer toileting to minimize incontinent episodes and excessive exposure to moisture. -Check the inside of the resident's shoes for rough areas that may rub on the foot and check shoes for appropriate fit. On 7/12/17 at 10:05 AM, Resident #10 was interviewed and stated the staff did not start elevating his heels until after the blister developed on the heel.	F 314		