DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				SURVEY PLETED
		165453	B. WING			08/	14/2017
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O			1 E POLK ST ASHINGTON, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	00			
	Amended after IDR-I	С.					
	Correction Date						
	recertification and inv 69642-C, 69219-C, 69	cies relate to the annual estigation of complaints 9148-C, 69153-C, and eported incident 69244-I, 7 to 8/010/17.					
	69153-C and facility r	69219-C, 69148-C, and eported incident 69244-I complaint 68577-C was not					
F 156 SS=D	482, Subpart B. NOTICE OF RIGHTS CHARGES	Regulations (42CFR) Part , RULES, SERVICES, (g)(1)(4)(5)(13)(16)-(18)	F 1	56			
	remains informed of the of contacting the physical sectors and the physical sectors are set of the physical sectors and the physical sectors are set of the physical sectors are sectors are sectors are sectors are sectors a	at ensure that each resident he name, specialty, and way sician and other primary care sible for his or her care.					
	(1) The resident has t his or her rights and c	n and Communication. he right to be informed of of all rules and regulations nduct and responsibilities in the facility.					
		ng spoken) and in writing format and a language he					
		SUPPLIER REPRESENTATIVE'S SIGNATURI	=		TITLE		(X6) DATE

08/28/2017

PRINTED: 01/12/2018

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/12/2018 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		SURVEY
		165453	B. WING				08/	14/2017
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP	CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O			01 E POLK ST VASHINGTON, IA 52353			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B		(X5) COMPLETION DATE
F 156	The facility must furnidescription of legal rig (A) A description of the personal funds, under section; (B) A description of the procedures for establi- including the right to re- resources under section Security Act. (C) A list of names, and email), and telephone State regulatory and i- resident advocacy gro Survey Agency, the S State Long-Term Care- protection and advoca- services where state I- in long-term care facil agency for information community and the M and (D) A statement that the concerning any suspe- federal nursing facility, not limited to resident exploitation, misappro- in the facility, non-con- directives requiremen information regarding	s specified in this section. sh to each resident a written ghts which includes - he manner of protecting r paragraph (f)(10) of this he requirements and ishing eligibility for Medicaid, request an assessment of ion 1924(c) of the Social ddresses (mailing and e numbers of all pertinent nformational agencies, bups such as the State itate licensure office, the e Ombudsman program, the acy agency, adult protective law provides for jurisdiction lities, the local contact in about returning to the ledicaid Fraud Control Unit; he resident may file a ate Survey Agency exted violation of state or v regulations, including but abuse, neglect, opriation of resident property npliance with the advance	F	156				
	(ii) Information and co	intact information for State						

Facility ID: IA0948

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/12/20 FORM APPROV OMB NO. 0938-03		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		165453	B. WING		08/14/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST			
	l			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 TH DEFICIENC'	ON SHOULD BE COMPLETIC HE APPROPRIATE DATE		
F 156	and local advocacy o not limited to the Stat Long-Term Care Omt (established under se Americans Act of 196 U.S.C. 3001 et seq) a advocacy system (as as established under Disabilities Assistanc 2000 (42 U.S.C. 1500 [§483.10(g)(4)(ii) will November 28, 2017 ((iii) Information regare eligibility and coverag [§483.10(g)(4)(iii) will November 28, 2017 ((iv) Contact informatio Disability Resource C Section 202(a)(20)(B Act); or other No Wro [§483.10(g)(4)(iv) will November 28, 2017 ((v) Contact informatio Control Unit; and [§483.10(g)(4)(v) will November 28, 2017 ((vi) Information and c grievances or compla suspected violation o facility regulations, in resident abuse, negle	rganizations including but the Survey Agency, the State budsman program ection 712 of the Older 35, as amended 2016 (42 and the protection and designated by the state, and the Developmental e and Bill of Rights Act of 01 et seq.) be implemented beginning (Phase 2)] ding Medicare and Medicaid ge; be implemented beginning (Phase 2)] on for the Aging and Center (established under)(iii) of the Older Americans ong Door Program; be implemented beginning (Phase 2)] on for the Medicaid Fraud be implemented beginning (Phase 2)] on for the Intervence of the filling aints concerning any f state or federal nursing cluding but not limited to ect, exploitation, esident property in the	F 1	56			

Facility ID: IA0948

If continuation sheet Page 3 of 56

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/12/2018 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY
		165453	B. WING		_	08/ [,]	14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 5235	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 156	 (g)(5) The facility must manner accessible arresidents, resident rep (i) A list of names, add and telephone number agencies and advoca Survey Agency, the Sprotective services whill jurisdiction in long-ter of the State Long-Terr program, the protection home and community and the Medicaid Frant (ii) A statement that the complaint with the State concerning any suspect federal nursing facility limited to resident about misappropriation of refacility, and non-complicatives requirement 1) and requests for infit to the community. (g)(13) The facility must for admission information about how Medicare and Medicaire and	returning to the community. at post, in a form and ad understandable to presentatives: dresses (mailing and email), ers of all pertinent State cy groups, such as the State itate licensure office, adult here state law provides for m care facilities, the Office m Care Ombudsman on and advocacy network, based service programs, ud Control Unit; and he resident may file a ate Survey Agency ected violation of state or regulation, including but not use, neglect, exploitation, esident property in the bliance with the advanced ts (42 CFR part 489 subpart ormation regarding returning ust display in the facility hd provide to residents and ion, oral and written v to apply for and use id benefits, and how to evious payments covered by ust provide a notice of rights	F 156				
	such benefits. (g)(16) The facility mu						

Facility ID: IA0948

If continuation sheet Page 4 of 56

	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		165453	B. WING			08/	14/2017
NAME OF F	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O			POLK ST HINGTON, 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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 156	admission and during (i) The facility must in and in writing in a lan- understands of his or regulations governing responsibilities during (ii) The facility must a the State-developed r obligations, if any. (iii) Receipt of such in amendments to it, mu- writing; (g)(17) The facility mu (i) Inform each Medic writing, at the time of facility and when the r Medicaid of- (A) The items and ser nursing facility service for which the resident (B) Those other items facility offers and for v charged, and the amo services; and (ii) Inform each Medic changes are made to specified in paragraph this section.	the resident's stay. form the resident both orally guage that the resident her rights and all rules and resident conduct and the stay in the facility. Iso provide the resident with notice of Medicaid rights and formation, and any ist be acknowledged in ust aid-eligible resident, in admission to the nursing resident becomes eligible for	F 1	56			

Facility ID: IA0948

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/12/2018 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				(X3) DATE	
		165453	B. WING			_	08/	14/2017
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O			01 E POLK ST VASHINGTON, IA 5235	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 156	before, or at the time periodically during the available in the facility services, including an covered under Medica facility's per diem rate (i) Where changes in and services covered Medicaid State plan, the notice to residents of reasonably possible. (ii) Where changes are items and services that facility must inform the 60 days prior to imple (iii) If a resident dies of transferred and does facility must refund to representative, or esta deposit or charges all per diem rate, for the resided or reserved of facility, regardless of a discharge notice require (iv) The facility must r resident representative the resident within 30 date of discharge from v) The terms of an ad behalf of an individual facility must not confli- these regulations.	of admission, and e resident's stay, of services y and of charges for those by charges for services not are/ Medicaid or by the are/ Medicaid or by the s. coverage are made to items by Medicare and/or by the the facility must provide the change as soon as is re made to charges for other at the facility offers, the e resident in writing at least ementation of the change. or is hospitalized or is not return to the facility, the the resident, resident ate, as applicable, any ready paid, less the facility's days the resident actually r retained a bed in the any minimum stay or tirements. refund to the resident or /e any and all refunds due days from the resident's	F	156				

Facility ID: IA0948

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(V3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · /	PLETED
		165453	B. WING		08	/14/2017
AME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
EARL VA	ALLEY REHABILITATION	& HEALTHCARE CENTER O		1 E POLK ST ASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 156	Continued From page	e 6	F 156			
	failed to provide the a Medicare coverage c	oming to an end for 1 of 3 Resident # 13) The facility				
	Findings:					
	received Medicare be starting 9/19/16 and e resident's Skilled Nur Beneficiary Notice re- resident of services e notice lacked docume	sing Facility Advance vealed the facility notified the ending on 10/5/16. The entation the facility notified rvices ending 48 hours prior				
F 157 SS=D	10:43 a.m., the Regio	ES ROOM, ETC)	F 157			
	(g)(14) Notification of	Changes.				
	consult with the resid	nediately inform the resident; ent's physician; and notify, her authority, the resident en there is-				
		ving the resident which as the potential for requiring				

Facility ID: IA0948

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE	
		165453	B. WING			08/	14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE		(X5) COMPLETION DATE
F 157	mental, or psychosoc deterioration in health status in either life-thr clinical complications (C) A need to alter trea a need to discontinue treatment due to adve commence a new form (D) A decision to trans- resident from the facil §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent information is available and provi- physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must r update the address (r phone number of the This REQUIREMENT by: Based on record revi-	 ial status (that is, a a, mental, or psychosocial reatening conditions or); eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment I0(e)(6); or ent rights under Federal or ns as specified in paragraph . record and periodically mailing and email) and resident representative(s). is not met as evidenced ew, staff interview, and 	F 1	57			

Facility ID: IA0948

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/12/2018 MAPPROVED). 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE	
		165453	B. WING			_	08/	14/2017
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O			01 E POLK ST VASHINGTON, IA 5235	53		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD E NCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	diabetes (Resident #1 census of 49 resident Findings include: The Admission Minim assessment reference revealed a Brief Interv (BIMS) score of 8 whi impaired long and sho Resident # 17 receive change in the Physici this assessment period included a transient is essential tremor. The plan of care initia a diagnosis of diabeted directed licensed staff for diabetes as ordered for hypo or hyperglyce sugars), and to check times a day. Review of the June 20 Administration Record 17 admitted on 06/02/ sugars (finger sticks to June 5, 6, 9, and 11.	esident's reviewed with 17). The facility reported a s. hum Data Set (MDS) with an e date of 06/13/2017 view for Mental status ich indicated moderately ort term memory issues. ed 7 insulin injections and 1 an's orders for insulin during od. Resident #17's diagnosis schemic attack (TIA) and an ted on 06/14/2017 included es mellitus. The plan f to administer medication ed by the Physician, assess emia (low or high blood the blood glucose levels 4 017 Treatment d (TAR) revealed Resident # /2017, revealed low blood o check sugar levels) on	F	157				
	as 43 for 11:00 A.M., P.M., the blood sugar	and on 06/09/2017 at 4:30 level was 67. Blood sugars isually vary between 90 and ailed to contain any ated staff notified the						

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						IO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED
		165453	B. WING		08/14/2017	
AME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
EARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 157	Continued From page	9	F 15	7		
		he TAR documentation				
		eld the insulin at 4:30 P.M.				
		lood sugar level of 44 and				
		at 06:45 A.M. (for 125) and				
	failed to contact the F	on 06/11/2017. The facility				
	notification of the low					
	decision to hold the in					
	In an interview on 08/	/09/2017 at 1:30 P.M., Staff				
		verbalized not recalling				
		ine 10 and 11, but did				
		sugar level the night before ailed to call the Physician,				
		ecause of the low blood				
		e. She stated not knowing				
	what the facility policy do for a low blood sug	/ guidelines directed staff to gar.				
		/09/2017 at 02:20 P.M., the				
	-	ated being aware of the low				
		nsulin being held over June N reported calling the				
		e incidents. The Physician				
		r blood sugars under 70 and				
	over 350.					
	During an interview a	t 20:30 P.M. on 08/09/2017,				
	the Nurse Practitione	r verbalized the nurse				
		e Physician on the low blood				
		n on June 9-11. The Nurse rsing needed an order to				
		ow blood sugars needed to				
	be reported.					
	The undated Blood G	lucose Monitoring Protocol				
	procedure directed lic	censed staff to notify the				
	Physician if the finger	stick for blood sugars ran				

Facility ID: IA0948

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/12/2018 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		165453	B. WING			08/	/14/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O			01 E POLK ST VASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279 SS=D		HENSIVE CARE PLANS 3.21(b)(1)	F	279			
	assessments complet months in the residen results of the assessm	st maintain all resident ted within the previous 15 it's active record and use the nents to develop, review nt's comprehensive care					
	483.21 (b) Comprehensive C	are Plans					
	comprehensive perso each resident, consist set forth at §483.10(c includes measurable to meet a resident's m and psychosocial nee	levelop and implement a on-centered care plan for tent with the resident rights ()(2) and §483.10(c)(3), that objectives and timeframes nedical, nursing, and mental eds that are identified in the ssment. The comprehensive ibe the following -					
	or maintain the reside physical, mental, and	are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and					
	under §483.24, §483.						
	provide as a result of	the nursing facility will					

Facility ID: IA0948

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF D AND PLAN OF CC	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		165453	B. WING			08/	14/2017
NAME OF PROV	IDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		-
PEARL VALL	EY REHABILITATION	& HEALTHCARE CENTER O			501 E POLK ST NASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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
fir ra (iv re (A da (E fu w cc lo el (C pl re se TI by E in in re fa to th fa (F fu w cc lo el (C fu w cc lo el (C) fu w cc lo (C) fu v cc lo (C) fu v cc lo (C) fu v cc lo (C) fu v cc lo (C) fu v cc lo (C) fu v cc (C) fu (C) fu v cc (C) fu v cc (C) fu v cc (C) fu fu fu fu fu fu fu fu fu fu fu fu fu	All consultation with esident's representat (A) The resident's goal esired outcomes. (B) The resident's pre- ture discharge. Faci- hether the resident's cal contact agencies cal contact agencies cal contact agencies ontities, for this purpo (C) Discharge plans in an, as appropriate, i equirements set forth ection. (C) Discharge plans in an, as appropriate, i et existing care plan (C) Discharge plans in and (C)	RR, it must indicate its nt's medical record. In the resident and the ive (s)- als for admission and ference and potential for lities must document a desire to return to the ssed and any referrals to a and/or other appropriate	F	279			

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · /	I SORVET IPLETED
		165453	B. WING		0	8/14/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	E	
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		01 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 PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 279	dressing, extensive a mobility, depended to hygiene and bathing, staff for transfers and the resident did not w and listed the resident Mental Status) score intact cognition. A fall incident report, nurse received a pho the resident's roomm needed help. The nu Nursing Assistant) to assisted the resident the bed. At 10:57 p.m second phone call fro who stated the reside stated the nurse resp resident was on the fl his/her left leg buckle resident was crying o my hip pop when I rol trying to adjust mysel bed and then I rolled report stated the facil hospital. A care plan entry, rev resident was at high r	ssistance of 1 staff for ssistance of 2 staff for bed stally on 1 staff for personal and depended totally on 2 toilet use. The MDS stated valk during the review period at's BIMS(Brief Interview for as 15 out of 15, indicating dated 7/9/17, stated the ne call at 10:51 p.m. from ate who stated the resident irse sent a CNA(Certified the room and the CNA to get his/her feet back into n., the nurse received a om the resident's roommate ent needed help. The report onded immediately and the loor beside the bed with d under him/her. The ut in pain and stated "I felt lled out of bed, I was just f when my legs fell out of out onto the floor." The ity sent the resident to the vised 11/3/16, documented d all 4 bed rails up.	F 279			

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		MEDICAID SERVICES				O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED
		165453	B. WING		08	8/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 279	Continued From page	e 13	F 279	9		
	and encourage the re					
		s to wheelchair to prevent it				
	from tipping forward					
	 c. Physical therapy t ordered and as need 	o evaluate and treat as ed				
	The care plan lacked	any interventions to prevent				
	the resident from slip					
		side rails, dated 6/28/17, ttom side rails were strictly				
	-	on 7/13/17 at 5:05 a.m., Staff				
		rked at the facility on 7/9/17 a.m. He stated aside from a				
		init, he was the only CNA in				
		is the nurse. He stated he				
		resident when Resident				
		n. Resident #19's roommate				
		the phone for help and Staff				
		k on him/her. When he th of the resident's legs were				
		ed. Staff N placed the				
	resident's legs back i					
		ws on each side. Staff N				
		resident and Staff O found				
		/she fell which Staff O				
	-	11:00 p.m. He stated the				
		r have his/her legs out of the ails were on the bed. He				
		equested all 4 side rails and it				
		and the resident was upset				
		the lower side rails anymore.				
	-	on 7/12/17 at 10:55 a.m., the				
		stated Resident #19 fell				
		0:30-10:45 p.m. He/she				
	stated she thought th	e facility removed the				

Facility ID: IA0948

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/12/2018 1 APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	-	(X3) DATE : COMPL	SURVEY
		165453	B. WING			08/	14/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
PEARL VA	ALLEY REHABILITATION	& HEALTHCARE CENTER O		01 E POLK ST VASHINGTON, IA 5235	53		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279	resident's side rails so resident started to slip couple times before the During an interview of MDS Coordinator stat from the care plan du stated the owners dire not have all 4 side rai She stated maintenar side rails from every r During an interview of resident's daughter st roommate told her 2-3 resident had been fall During an interview of P CNA stated at one the rails and was very and removed 2 of the side he/she had only 2 sid his/her room and see bed and would need to them back. During an interview of Maintenance Supervisi instructed him to remo- from some beds and si mandated decision."	ometime last week and the o his/her legs out of bed a his fall. n 7/12/17 at 11:20 a.m., the ted she removed 4 side rails e to "company policy". She ected that residents could ls because it was a restraint. nce removed the lower 2 resident who had them. n 8/8/17 at 11:04 a.m., the tated the resident's 3 days prior to the fall the ling out of bed. n 8/8/17 at 11:20 a.m., Staff time the resident had 4 side gry when the facility e rails. She stated after e rails, staff would walk by his/her feet dangling out of to go in and help him/her put n 8/9/17 at 9:16 a.m., the sor stated the Administrator ove the 2 bottom side rails stated it was a "state n 8/8/17 at 11 :36 a.m., the sing) stated the facility s side rails and staff put a ent's sheet to keep him/her	F 279		DEFICIENCY)		

Facility ID: IA0948

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/12/2018 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE	
		165453	B. WING			08	/14/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O			1 E POLK ST ASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	listed diagnoses for F muscle weakness, so artery disease. The f required supervision limited assistance of and extensive assista mobility, transfers, dr bathing. The MDS st walk during the review and only able to stabi- when moving from se moving on and off the between bed and cha- stated the resident ha- injury since the last a resident's BIMS score moderately impaired During an observation resident lay in bed. N front of the bed. The the resident. During an observation resident's door was a (open approximately bed and no floor mat bed. A sign on the ou- the resident. During an observation door was completely During an observation the resident.	nent tool, dated 5/26/17, Resident #14 included chizophrenia, and coronary MDS stated the resident assistance with eating, 1 staff for personal hygiene, ance of 1 staff for bed essing, toilet use, and tated the resident did not w period and was not steady ilize with staff assistance eated to standing position, e toilet, and transferring air or wheelchair. The MDS ad 2 falls resulting in no ssessment and listed the e as 8 out of 15, indicating cognition. n on 8/7/17 at 3:00 p.m., the No floor mat was present in call light was not in reach of n on 8/8/17 at 8:06 a.m., the limost completely closed 1 inch). The resident lay in was present in front of the utside of the door directed e staff for assistance. With sign could not be seen by the	F	279			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/12/2018 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		165453	B. WING			08/	14/2017
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O			101 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	CNA told the resident needed anything. Sta the resident to the toil anything in his/her roo wheeled himself/herse closed the door until in The resident stood up wheelchair, turned arc Progress notes, dated documented a staff m on the floor and the re after trying to turn aro resident complained of pain. A 12/6/16 10:40 a.m. staff found the resider bathroom. The resider feet tangled and fell o stated the resident su listed the interventions resident to ask for ass of grab bars in the bat A 12/14/16 3:00 a.m. resident transferred so and the wheelchair ro The resident sustaine intervention listed to p anti-roll back to wheel	to pull the call light if he/she aff H did not offer to assist let or assist the resident with om. The resident then elf into his/her room and t was open about 1 inch. by himself/herself from the ound, and sat on the bed. d 11/12/16 5:53 a.m. tember found the resident esident stated he/she fell ound in the bathroom. The of leg, knee, and side hip incident report stated the nt lying on the floor of the ent stated he/she got his/her in the buttocks. The report istained no injuries and s of encouraging the sistance and the installation throom. incident report stated the lige of the bed and slid onto ad no injury. incident report stated the elf from bed to wheelchair illed and he/she slid out. d a skin tear and the orevent a recurrence was lchair and to make the 1 staff for transfers. The	F	279			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		165453	B. WING			08/	14/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>,</u>	
PEARL VA	ALLEY REHABILITATION	& HEALTHCARE CENTER O			01 E POLK ST /ASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 279	Progress notes, dated a staff member found and the resident hit hi and complained of pa- to the back. The incid resident went to the e A 12/14/16 3:43 p.m. resident had a superfi (tearing) of the right g A 5/4/17 hospital repo- from the toilet while si contusions (bruises). A 5/5/17 incident repo- themselves to the bat the floor, and complai shoulder. A 5/22/17 incident repo- the resident on the floo The resident on the floo The resident stated his bathroom and started roommate came over shook so much he/sh down on the floor. The resident sustained no A 5/23/17 radiology re had mild compression potentially new since unknown. The report compression fractures Progress notes, dated entry), documented si	d 12/14/16 5:05 p.m., stated the resident on the floor is/her head against the bed in from his/her neck down lent report revealed the emergency room. hospital report stated the icial (not deep) skin avulsion great toe. ort revealed the resident fell leeping and sustained hip ort revealed the resident took throom, fell off the toilet onto ined of pain in the right port documented staff found oor by the bathroom door. e/she came out of the shaking. The resident's to help but the resident sat he report revealed the resident sat he report revealed the resident e let go and the resident sat he report revealed the resident he deformities which were 2/20/16, but duration documented chronic	F2	279			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/12/2018 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		165453	B. WING			08/	14/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL VA	ALLEY REHABILITATION	& HEALTHCARE CENTER O			01 E POLK ST VASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	room. A hospital report, date resident had a fall witt mild closed head injur A 5/25/17 fall incident tried to get out of bed the floor, and sustaine toe. The report docur resident a high/low be to use the call light, and in front of the bed. A 5/25/17 physician's Occupational Therapy evaluate and treat. A 5/25/17 Therapy So resident had difficulty life, reduced upper/low muscle weakness, diff (transfers), and was a screening recommend Therapy and Physical The facility could not indicated the resident	e resident to the emergency ed 5/24/17, stated the h a right hip bruise and a ry. treport revealed the resident without assistance, slid to ed an abrasion to the left mented the facility gave the ed, re-instructed the resident nd placed a mat on the floor order displayed an order for y and Physical Therapy to creening Form revealed the performing activities of daily wer extremity functioning or fficulty with mobility at risk for falls. The ded both Occupational I Therapy for the resident. provide documentation that began Occupational	F 2	279			
	the resident lying on t wheelchair. The resid the bathroom and did the chair. The report sustained no injuries	ort revealed a nurse found the floor in front of the dent stated he/she went to n't quite make it back to the					

Facility ID: IA0948

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/12/2018 // APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE	
		165453	B. WING		_	08/	14/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		01 E POLK ST VASHINGTON, IA 5235	53		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279	Continued From page	9 19	F 279				
	resident lying on the r	port stated staff found the right side on the floor in front ne report stated the resident					
	tried to urinate in the tand fell on a mat near	ort documented the resident trash, lost his/her balance, r the bed. The resident go to the bathroom and lost					
	The care plan include entries:	d the following dated					
	transfer. 7/17/17 The resident maximum assist of 1 = 6/15/17 Attempt to to 7/11/17 Be sure the r reach.	required supervision to required moderate to staff with transfers. bilet before/after meals. resident's call light is within					
	the resident required The care plan also lac directed the staff to le	mat beside the bed. clarity as to whether or not assistance with transfers. cked documentation that eave the resident's door n intervention on a fall					
	resident as at high ris During an interview of CMA (Certified Medic	sessment assessed the sk for falls. n 8/7/17 at 3:30 p.m., Staff I ation Aide) stated the re assistance with transfers.					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		165453	B. WING			08/	14/2017
NAME OF PF	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O			01 E POLK ST VASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 279	Continued From page	20	F	279			
	-	n 8/8/17 at 8:15 a.m., Staff J ent went to the bathroom					
	H CNA stated the residuel help with transfers but	n 8/8/17 at 9:29 a.m., Staff ident sometimes needed it sometimes transferred to he could help him/her.					
	MDS Coordinator stat resident assistance w the resident was likely staff did not always co	n 8/9/17 at 11:00 a.m., the ted staff should offer the vith transfers. She agreed y to fall again and stated communicate new fall o she could add them to the					
F 281 SS=E	Director of Nursing st take the resident to th resident had a mat bu the room. She stated work on changing the SERVICES PROVIDE	8/8/17 at 11:36 a.m., the ated staff should attempt to be bathroom. She stated the ut staff kept removing it from I the facility was going to care plans in the future. ED MEET PROFESSIONAL (i)	F	281			
	(b)(3) Comprehensive	e Care Plans					
		d or arranged by the facility, nprehensive care plan,					
	(i) Meet professional s This REQUIREMENT by: Based on observation	is not met as evidenced					

Facility ID: IA0948

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	-	D HUMAN SERVICES				FORM	: 01/12/2018 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE	
		165453	B. WING		-	08/ [,]	14/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	_	
PEARL VA	ALLEY REHABILITATION	& HEALTHCARE CENTER O		01 E POLK ST VASHINGTON, IA 52353	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 281	interview, the facility f orders for 3 of 16 resi #4, #14, and #17). Th of 46 residents. Findings include: 1. The MDS (Minimu tool, dated 7/18/17, lis #4 included heart failt obstructive pulmonary disease, and obesity. resident required exter for personal hygiene, staff for bed mobility a totally on 1 staff for ba on 2 staff for transfers stated the resident re- listed the resident s B Mental Status) score intact cognition. During an observatior the resident lay in bed nasal cannula. The or liters. During an observatior resident lay in bed an cannula. The oxygen over 3 liters. Admission orders, dat	ailed to carry out physician's dents reviewed (Resident ne facility reported a census m Data Set) assessment sted diagnoses for Resident ure, asthma, chronic y disease, or chronic lung	F 281				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/12/2018 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		165453	B. WING			08/	/14/2017
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O			601 E POLK ST WASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	Continued From page	22	F	281			
	3:00 p.m., the ADON Nursing) stated she will abeling each oxygen the appropriate setting 2. The MDS assessing listed diagnoses for R muscle weakness, sc artery disease. The M required supervision a limited assistance of and extensive assistant mobility, transfers, dre bathing. The MDS st walk during the review and only able to stabil when moving from se moving on and off the between bed and char stated the resident has injury since the last as resident's BIMS score moderately impaired of A 5/17/17 physician's had new and old com osteoporosis. The ph (lumbar sacral orthosis support the spine) and a DEXA scan (a scan and treatment for oste the resident was at su	Yould begin a new system of machine to inform staff of g for each resident. Thent tool, dated 5/26/17, tesident #14 included hizophrenia, and coronary MDS stated the resident assistance with eating, 1 staff for personal hygiene, nce of 1 staff for bed essing, toilet use, and ated the resident did not v period and was not steady lize with staff assistance ated to standing position, toilet, and transferring ir or wheelchair. The MDS ad 2 falls resulting in no ssessment and listed the e as 8 out of 15, indicating					
	should return for a fol weeks.	low up appointment in 6 cked documentation of the					

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		ID HUMAN SERVICES				F	TED: 01/12/2018 DRM APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		STRUCTION	(X3) D	NO. 0938-0391 ATE SURVEY OMPLETED
		165453	B. WING				08/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	•	
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O			POLK ST INGTON, 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 281	osteoporosis treatme documentation the re or attended a follow u A 5/25/17 physician's Occupational Therapy evaluate and treat. A 5/25/17 Therapy So the resident had diffic daily life, reduced upp functioning or muscle mobility (transfers) ar screening recommen Therapy and Physica The facility lacked do began Occupational Therapy. During an interview o Nursing stated she ne brace. During an interview o ADON (Assistant Dire facility didn't have "m from orthopedics and the 6 week follow-up stated the local clinic and she didn't realize arrived at the clinic. S an x-ray in lieu of the During an interview o Regional Vice Preside received a therapy ev	A scan or the initiation of nt and lacked sident received a LSO brace up appointment in 6 weeks. • order displayed an order for y and Physical Therapy to creening Form documented culty performing activities of per/lower extremity • weakness, difficulty with nd was at risk for falls. The ded both Occupational I Therapy for the resident. • cumentation the resident Therapy or Physical • 8/8/17 the Director of ever saw the resident wear a • 8/8/17 at 11:45 a.m., the ector of Nursing) stated the uch luck" obtaining a brace I stated Hospice canceled with the physician. She didn't carry out DEXA scans • this until the resident had	F 2	281			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED DMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		165453	B. WING			08/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	
F 281	Hospice "probably dro 3. The Initial Minimur assessment reference revealed a Brief Inter- (BIMS) score of 8 whi impaired long and sho Resident # 17 receive toilet use and persona urinary catheter provi- the body into an exter- care of. Diagnoses in attack (TIA), an esser- weakness. The plan of care initia additional diagnoses fibrillation, diabetes m depression. The plan catheter tubing below cares, monitor and do assess for pain. On 06/03/2017, a New Resident's sheet disp French urinary catheter signed the order sheeter Physician's Order Sheeter Signed by the Physicion order for an indwelling The August Treatment (TAR) failed to contain urinary catheter. Observations of Resident at 10:45 A.M. and 4:52 8:00 A.M. and at 2:25	apped him". In Data Set (MDS) with an a date of 06/13/2017 view for Mental status ich indicated moderately port term memory issues. ed limited assistance with al hygiene. An indwelling ded release of urine from rnal bag which staff took included a transient ischemic intial tremor, and muscle ited on 06/14/2017 included of diabetes mellitus, atrial nellitus, and major directed staff to keep the bladder level when doing bocument urine output, and w Orders on Current layed an order for a size 16 er. The Physician never et. The most current eet signed 07/30/2017 an, failed to document an g urinary catheter. It Administration Sheet in an order for the indwelling dent # 17 on August 7, 2017 i0 P.M., August 8, 2017 at	F 2	81		

	-					FORM): 01/12/2018 1 APPROVED
STATEMENT (S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		165453	B. WING		_	08/ [,]	14/2017
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		01 E POLK ST VASHINGTON, IA 52353	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281 F 314 SS=G	An observation on Au Staff K and Staff M (C entered Resident # 17 washed their hands a explained the cares th the resident. An observealed an indwelling Resident # 17. During an interview of the Assistant Director for the Foley catheter placed on the 07/31/2 Sheet and TAR. No c unsigned order on 06 TREATMENT/SVCS PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. If comprehensive assess facility must ensure th (i) A resident receives professional standard pressure ulcers and d ulcers unless the indiv demonstrates that the (ii) A resident with pre- necessary treatment a professional standard healing, prevent infec- from developing.	Agust 7, 2017 at 11:17 A.M., Certified Nursing Assistants) 7's room, closed the door, and donned gloves. Staff K hey would be completing for ervation of the cares g urinary catheter for an 07/09/2017 at 3:40 P.M., of Nursing stated the order must have missed being 2017 Physician's Order current order other than the 5/03/2017 could be located. TO PREVENT/HEAL Based on the ssment of a resident, the	F 281				

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIPI F	CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,			IPLETED
		165453	B. WING		08	3/14/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O		01 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 PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 314	Based on observatio interviews the facility pressure sores for 1 of pressure sores (Resi- reported a census of Findings include: The Admission Minim 6/20/17 documented of 15 for the brief inter (severely impaired co- decision making). The resident required total bed mobility, transfer also documented limit one side of lower and the resident had diag vascular accident (str rhythm. The MDS doc pressure reducing de The MDS documenter a repositioning progra medications for skin t feet. The Nurses Progress p.m. documented the needle stick areas, th areas present, the rig centimeter (cm) by 2 had two, 0.5 cm by 0 and a 2 cm by 1 cm a documentation lacker coccyx area. The res documentation of furt	n, record review, and failed to prevent two of 1 residents reviewed with dent #2). The facility 46 residents. hum Data Set (MDS) dated Resident #2 scored a 3 out erview for mental status ognitive skills for daily e MDS documented the all assistance of two staff for s, and dressing. The MDS tation in range of motion for a upper extremity. The MDS noses that included cerebral roke) and an irregular heart cumented the resident had a vice for the bed and chair. ed the resident had been on am, and had applications of treatments other than to the a Note dated 6/13/17 at 3:15 resident had inner elbow the coccyx area had scabbed th buttock had a 1.5 cm area, and the left buttock .5 cm circular areas on top area on the bottom. The d measurements of the ident's record lacked ther assessment to the s, and the inner elbow	F 314			

Facility ID: IA0948

If continuation sheet Page 27 of 56

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE	
		165453	B. WING			08/	/14/2017
NAME OF P	ROVIDER OR SUPPLIER	<u></u>		ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PEARL VA	ALLEY REHABILITATION	& HEALTHCARE CENTER O			1 E POLK ST ASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 314	Continued From page	27	F 3	14			
The Skin Observation tool dated 6/14/17 documented the same areas mentioned in the Nurses Progress Note dated 6/13/17.							
	The Braden Scale for Predicting Pressure Sore Risk dated 6/13/17 documented the resident had slightly limited sensory perception, occasional moist skin, very limited mobility, very poor nutrition, and a friction and shear problem. The Braden Scale also documented the resident required moderate to maximum assistance with moving, frequently slides down in bed or chair, and required frequent repositioning with maximum assistance.						
		on Assessment Note dated acked documentation of any					
	The Nurse Practitioner Progress Note dated 6/16/17 documented that the resident had resolving diarrhea related to infectious C. difficile, and was on antibiotic course of oral vancomycin. The Nurse Practitioner Progress Note dated						
		the resident's had a coccyx sed upon admission, but it					
	•	Noted dated 6/16/17 at d the resident defecated					
	p.m. documented the feet were very dry an	s Note dated 6/18/17 at 4:19 nurse noticed the resident's d and lotion applied. At that the resident's left heel had ne nurse notified the					

Facility ID: IA0948

If continuation sheet Page 28 of 56

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/12/2018 APPROVED . 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMPI	
		165453	B. WING		_	08/ [,]	14/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 5235	53		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314	Continued From page		F 31	1			
	physician and family. the nurse notified the	The note did not indicate wound nurse.					
	at 6:43 p.m. directed transfers and to positi wheelchair for two ho hours in the afternoor staff to float heels at a when in the wheelcha The Skin Wound Note	urs in the morning and two n. The Note also directed all times and use boots					
	open area to the inter previously been open admission here), whic odor, or other signs o Note directed staff to each episode of incor had multiple episodes directed staff to repose floating and pillows pr	realate crease (area had at hospital prior to ch was without drainage, r symptoms of infection. The apply barrier cream after ntinence as the resident still s of soft stool. The Note sition the resident with heels roviding support. The Note lent had been non-compliant nd repeatedly rolled					
	6/28/17 documented a intergluteal cleft on 6/ 15 millimeters (1.5 ce (0.7 centimeters), and centimeters). The Too	Observation Tool dated an acquired area to the '26/17 with that measured entimeters) x 7 millimeters d depth 2 millimeters (0.2 ol documented the visible epithelial moist tissue,					
		veekly wound assessments e intergluteal cleft area after o 7/19/17.					

If continuation sheet Page 29 of 56

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/12/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		165453	B. WING		08/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	•
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST	
				WASHINGTON, IA 52353	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION (X5) VE ACTION SHOULD BE COMPLETION ED TO THE APPROPRIATE ICIENCY)
F 314	7/19/17 documented measured 15 millimed depth of depth 2 millin documented the visib dry without drainage. The Wound Weekly O 7/5/17 documented a heel on 6/29/17 that r 70 millimeters with no documented this had The area to the left ha Nurse Progress Note assessment of the area The Wound Weekly O 7/19/17 documented 45 millimeters x 30 m dry skin. The Wound Clinic Pro documented the cocco presented as a Stage heel wound could hav tissue injury, so it nee The nature of the wou Heel; small dark pink serous fluid in severa where a large, dry, bl removed. After the es centimeter by 3 centin blanchable dark pink new epithelium remai measured 2 centimeter a depth of 0.15 centir bed appeared clean,	Deservation Tool dated the intergluteal cleft ters x 11 millimeters, with a meters. The Tool ble tissue had been pink, and Deservation Tool dated n acquired area to the left measured 75 millimeters x o depth. The Tool been the first observation. eel had been identified by a dated on 6/18/17, but the lacked a complete ea. Deservation Tool dated left heel measurements of iillimeters and no depth, with ogress Note dated 8/1/17 cyx wound currently a 3 pressure injury and the we presented as a deep eded to be staged at a 3 or 4. und is pressure injury. Left spots and weeping of al spots on the post left heel ack eschar (scab) was schar had been removed a 1 meter linear area of non red tissue surrounded by	F 3	314	

Facility ID: IA0948

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/12/2018 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE : COMPL	SURVEY
		165453	B. WING			08/1	4/2017
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		01 E POLK ST VASHINGTON, IA 52353			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 314	Continued From page	30	F 314				
	appeared to be granu slough in the wound b	lation buds noted within the ed.					
	The facility did not pro an initial Care Plan fo	ovide the survey team with r the resident.					
	hours in the morning a boots while in the whe documented the resid assistance of two staf	neels in bed, have the eelchair twice a day for two and evening, and to wear eelchair. The Care Plan also					
	the resident had been with heel protectors o	n on 8/01/17 at 7:45 a.m., I laying on the back in bed, n. However, the resident's I the bed, and the Hoyer the resident.					
	the resident had been protectors on. Howev appeared worn and in	-					
	the residents left heel	n on 8/01/17 at 2:27 p.m., contained a large white and b with bloody drainage.					
	C and Staff D both ce	n 8/01/17 at 2:59 p.m., Staff rtified nurses aides reported nen the heel protectors					
		n 8/2/17 at 7:20 a.m., the sitioned on his/her back,					

Facility ID: IA0948

If continuation sheet Page 31 of 56

	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 01/12/201 FORM APPROVE OMB NO. 0938-039	ED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		165453	B. WING		_	08/14/2017	
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, S1	TATE, ZIP CODE		
PEARL VA	ALLEY REHABILITATION	& HEALTHCARE CENTER O		01 E POLK ST VASHINGTON, IA 5235	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	DATE	1
F 314	Continued From page with heels touching th		F 314				
	A, Licensed Practical resident had a blister is started by facility st skin had been started spongy heel, and then	n 8/2/17 at 9:12 a.m., Staff Nurse (LPN) reported if a or boggy heel no skin sheet aff. Staff A stated sheep when she first noticed the n later heel protectors were the resident had a standard					
	Certified Nurses Aide resident had a roho c had not been sure wh heel protectors. Staff should be out from un resident is in the bed.	n 8/2/17 at 9:43 a.m. Staff F, (CNA.) reported the ushion in the wheelchair, but then the facility started the F reported the Hoyer sling order the resident when the Staff F stated staff should y two hours while he/she is					
	G CNA reported staff was repositioned even	n 8/2/17 at 9:50 a.m., Staff were to assure the resident ry two hours, their heels ed, and heel protectors were dent was up in the					
	E, Registered Nurse r blister or spongy heel right away, and then	n 8/2/17 at 10:00 a.m. Staff reported if a resident had a , staff initiate a skin sheet notify the wound nurse, aff E could not remember fors started.					
	B, RN (facility wound expect staff to notify h	n 8/3/17 at 8:30 a.m. Staff nurse) reported she would ner of any skin changes; she ly measurements and also					

Facility ID: IA0948

If continuation sheet Page 32 of 56

CENTERS FOR MEDICARE & MEDICARE & MEDICARD SERVICES OMB NO. 033-039 AND FLAN OF CORRECTION (X1) PROVIDER/ORENTLETICULAR D2) MULTIPLE CONSTRUCTION (X0) DATE SUPPOY MALE OF PROVIDER OR SUPPLIER 185453 INVID 08/14/2017 IMME OF PROVIDER OR SUPPLIER 185453 STREET ADDRESS, CITY, STATE, 20 CODE 08/14/2017 PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O STREET ADDRESS, CITY, STATE, 20 CODE 08/14/2017 IMME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 20 CODE 08/14/2017 PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O STREET ADDRESS, CITY, STATE, 20 CODE 08/14/2017 IMME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 20 CODE 08/14/2017 IMME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 20 CODE 08/14/2017 IMME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 20 CODE 08/14/2017 IMME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 20 CODE 08/14/2017 IMME OF CONTRACTOR OR USE DEMINIVE WORKS PROVIDERS FLANCED TO THE APPROPRIATE 08/14/2017 IMME OF CONTRACTOR OR USE DEMINIVE WORKS PROVIDERS FLANCED TO THE APPROPRIATE 08/14/2017 IMME OF CONTRACTOR USE DEMINIVE WORKS AND TO THE APPROPRIATE 08/14/17 08/14/2017 IMME OF CONTRACTOR USE DEMINIVE WORKS AND TO THE APPROPRIATE 08/14/17 08/14/17 <th></th> <th>-</th> <th>ID HUMAN SERVICES</th> <th></th> <th></th> <th></th> <th>FORM</th> <th>MAPPROVED</th>		-	ID HUMAN SERVICES				FORM	MAPPROVED
NAME OF PROVIDER OR SUPPLIER Image: Control of the product of the	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 20° CODE BIT E POLK ST WASHINGTON, IA, 52353 (W10) PMPTRX TAG SUMMARY STATEMENT OF DEFICIENCES CACH CORRECTORY MUST ER PRECEDED BY VILL RECOLLATORY OR LSC DENTIFYING INFORMATION) PROVIDER IN OF CORRECTOR CACH CORRECTORY MUST ER PRECEDED BY VILL RECOLLATORY OR LSC DENTIFYING INFORMATION) PROVIDER CORRECTOR TAG Continued From page 32 do monthly rounds with the wound nurse from the hospital. F 314 During an interview on 8/3/17 at 8:52 a.m. Staff A, LPN reported the resident likes to lay on his/her back, and that they will be using more pillows now to help with heel protection. Staff A stated the resident frequently. Staff A reported she would have to frequently. Staff A reported she would have to frequently remind the CNAs to reposition the resident frequently. Staff A reported that the resident the protect that she did not know how oid the heel protectors were for the resident tag to more millows mow to how how oid the heel protectors were for the resident tag summany tag to the proposition the resident tag to the tag to the tag to the tag to the process to the owners of the resident, as they had found them in a closet. During an interview on 8/3/17 at 12:49 p.m. the DON reported the wedge cushion had been requested for purchase to the owners of the facility two weeks ago. During			165453	B. WING			08/	14/2017
PPARL VALLEY REHABILITATION & HEALTHCARE CENTER O WASHINGTON, IA 52333 (M) 10 PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH EDRIFS PLAN OF CORRECTION BE (EACH EDRIFS PLAN OF CORRECTION DB TE (EACH EDRIFS PLAN OF CORRECTION DB TE EACH EDRIFS PLAN OF CORRECTION DB TE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 005 DB TE (EACH EDRIFS PLAN OF CORRECTION DB TE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 005 DB TE DB TAG (EACH EDRIFS PLAN OF CORRECTION DB TE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 005 DB TE DEFICIENCY) F 314 do monthly rounds with the wound nurse from the hospital. F 314 do monthly rounds with the wound nurse from the hospital. F 314 do monthly rounds with the wound nurse from the hospital. F 314 do monthly rounds with the wound nurse from the hospital. F 314 do monthly rounds with the wound nurse from the hospital. F 314 do monthly rounds with the wound nurse from the hospital. F 314 do monthly rounds with the wound nurse from the hospital. F 314 do monthly rounds with the wound nurse from the resident had always been a very active person before the stroke. Staff A store ported that the resident frequently. Staff A reported she would have to frequently remind the CNAs to reposition the resident frequently. Staff A reported the would have to frequently remind the CNAs to reposition the resident and sometimes it was not getting done. During an interview on 8/3/17 at 12:38 p.m. the DON reported the wedge cushion had been requested for purchase to the owners of the facility two weeks ago. During an interview on 8/3/17 at 1:09 p.m. the DON reported that the yus ordered wedge cushions to be sent overnight for backups. During an interview on 8/3/17 at 1:09 p.m. the DON	NAME OF PI	ROVIDER OR SUPPLIER	•	- 1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PREFIX TXG (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC DENTFYING INFORMATION) PREFIX TXG (EACH OORRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 314 Continued From page 32 do monthly rounds with the wound nurse from the hospital. F 314 F 314 During an interview on 8/3/17 at 8:52 a.m. Staff A, LPN reported the resident likes to lay on his/her back, and that they will be using more pillows now to help with heel protection. Staff A stated the resident had always been a very active person before the stroke. Staff A also reported that the resident and surgitm around in bed, and staff need to keep repositioning the resident, and check on the resident frequently. Staff A reported she would have to frequently. Staff A reported she would have to frequently remind the CNAs to reposition the resident and sometimes it was not getting done. During an interview on 8/3/17 at 12:38 p.m. the Director of Nursing (DON) reported that facility does not have a skin/wound policy and procedure. The DON reported that she did not know how old the heel protectors were for the resident, as they had found them in a closet. During an interview on 8/3/17 at 12:48 p.m. the DON reported the wedge cushion had been requested for purchase to the owners of the facility two weeks ago. During an interview on 8/3/17 at 12:49 p.m. the DON reported that they just ordered wedge cushions to be sent overnight for backups. The Essential Services Invoice dated 7/20/17	PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O					
do monthly rounds with the wound nurse from the hospital. During an interview on 8/3/17 at 8:52 a.m. Staff A, LPN reported the resident likes to lay on his/her back, and that they will be using more pillows now to help with heel protection. Staff A stated the resident had always been a very active person before the stroke. Staff A also reported that the resident can squirm around in bed, and staff need to keep repositioning the resident, and check on the resident frequently. Staff A reported she would have to frequently remind the CNAs to reposition the resident and sometimes it was not getting done. During an interview on 8/3/17 at 12:38 p.m. the Director of Nursing (DON) reported the facility does not have a skin/wound policy and procedure. The DON reported that she did not know how old the heel protectors were for the resident, as they had found them in a closet. During an interview on 8/3/17 at 12:48 p.m. the DON reported the wedge cushion had been requested for purchase to the owners of the facility wo weeks ago. During an interview on 8/3/17 at 12:48 p.m. the DON reported that they just ordered wedge cushions to be sent overnight for backups. The Essential Services Invoice dated 7/20/17	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
	F 314	do monthly rounds wi hospital. During an interview of LPN reported the resident back, and that they wi to help with heel protor resident had always to before the stroke. Star resident can squirm at to keep repositioning the resident frequently have to frequently rent the resident and som done. During an interview of Director of Nursing (E does not have a skin/ procedure. The DON know how old the heer resident, as they had During an interview of DON reported the we requested for purchast facility two weeks ago During an interview of DON reported that the cushions to be sent of The Essential Service	ith the wound nurse from the In 8/3/17 at 8:52 a.m. Staff A, ident likes to lay on his/her rill be using more pillows now ection. Staff A stated the been a very active person aff A also reported that the around in bed, and staff need the resident, and check on y. Staff A reported she would mind the CNAs to reposition etimes it was not getting In 8/3/17 at 12:38 p.m. the DON) reported the facility /wound policy and reported that she did not el protectors were for the found them in a closet. In 8/3/17 at 12:48 p.m. the edge cushion had been se to the owners of the DON. In 8/3/17 at 1:09 p.m. the ey just ordered wedge overnight for backups. es Invoice dated 7/20/17	F	314			

Facility ID: IA0948

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	OF DEFICIENCIES	MEDICAID SERVICES	יסוד וו או (צ2)	E CONSTRUCTION	(X3) DATE	0. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	PLETED
		165453	B. WING		08/	14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL VA	ALLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 314	Continued From page	e 33	F 314	1		
F 323 SS=J		ISION/DEVICES	F 323	3		
	(d) Accidents. The facility must ensu	ure that -				
	(1) The resident envir from accident hazard	ronment remains as free s as is possible; and				
		eives adequate supervision es to prevent accidents.				
	appropriate alternativ bed rail. If a bed or s must ensure correct i	ails, including but not limited				
	(1) Assess the reside from bed rails prior to	ent for risk of entrapment				
		and benefits of bed rails with ent representative and obtain or to installation.				
		ed's dimensions are sident's size and weight. 「 is not met as evidenced				
	Based on observatio and family interview, implement interventio	n, record review, and staff the facility failed to ons to prevent a fall for 1 of 2 enced a fall that resulted in a				

Facility ID: IA0948

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	OF DEFICIENCIES	MEDICAID SERVICES	(¥2) MI II TI	PLE CONSTRUCTION		10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G		MPLETED
		165453	B. WING		0	8/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL V	LLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 323	Continued From page	e 34 ent future falls for 1 of 6	F 3	23		
		ry of falls (Resident #14).				
	environment remaine	d to ensure the resident ad as free from accident				
	(Residents #6, #15, # failed to implement a	for 3 of 12 residents sampled (#16). Specifically, the facility system to ensure gaps in				
	for entrapment and s	rge enough to create the risk erious injury which placed ediate jeopardy. The facility 46 residents.				
	' Findings include:					
		and Drug Administration's Safety Workgroup article,				
	"Clinical Guidance Fo Implementation of Be	or the Assessment and ad Rails In Hospitals, Long and Home Care Settings,"				
	dated April 2003, indi	-				
	documented clearly a	edical needs and should be and approved by the Bed rail use for patient's				
	mobility and/or transf and positioning withir	erring, for example, turning n the bed and providing a				
		into or out of bed, should be ire planInspect, evaluate, le				
	and remove potential	tresses/bed rails) to identify fall and entrapment hazards tch the equipment of patient				
	needs, considering a determined that bed	Il relevant risk factorsIf it is rails are requiredThe				
	individual from falling	nterface should prevent an between the mattress and nd monitoring of the bed,				

Facility ID: IA0948

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						IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	· · ·	E SURVEY IPLETED
		165453	B. WING		0	8/14/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 323	FDA Staff article, "Ho Dimensional and Ass Reduce Entrapment," years, FDA has received vulnerable patients has hospital beds while us treatment in health ca "entrapment" describ patient/resident is car in the space in or about hospital bed frame. If result in deaths and s received approximate over a period of 21 ye January 1, 2006. In the died, 120 were injure events with no serious intervention. These e occurred in openings between the bed rails rails, between split ra rails and head or foot most vulnerable to er patients and resident frail, confused, restler	ist itemsshould be Is Guidance for Industry and appital Bed System essment Guidance to " issued 3/10/06, "For 20 ved reports in which ave become entrapped in ndergoing care and are facilities. The term es an event in which a ught, trapped, or entangled but the bed rail, mattress, or Patient entrapments may serious injuries. FDA ely 691 entrapment reports ears from January 1, 1985 to these reports, 413 people d, and 158 were near-miss is injury as a result of entrapment events have within the bed rails, a and mattresses, under bed ils, and between the bed t boards. The population htrapment are elderly s, especially those who are ss, or who have uncontrolled trapments have occurred in	F 32			
	federally mandated re with an assessment r revealed a BIMS (Bri Status) of 15 which ir	imum Data Set (MDS- a esident assessment tool) reference date of 05/06/2017 ef Interview of Mental ndicated minimal or no long ory deficits. Resident # 6				

Facility ID: IA0948

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMP	LETED
		165453	B. WING			08/	14/2017
NAME OF PI	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	14/2011
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O					
	SI IMMADY ST	ATEMENT OF DEFICIENCIES		V	VASHINGTON, IA 52353 PROVIDER'S PLAN OF CORRECTION		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	36		323			
1 020		sistance from 1 staff for bed		525			
	mobility, transfers, pe	ersonal hygiene, and toilet					
		nented occasional bowel ndwelling urinary catheter to					
		e bladder. Active diagnoses					
		llitus, a seizure disorder,					
	psychotic disorder, ar	nd legally blind.					
		a problem revision date of					
		acility staff to use half rails					
		for safety, observe for t, monitor behaviors every					
		gression and psychosis,					
		ame plate to identify for risk					
	of falls, and monitor fo	or seizures.					
	An undated facility do Policy" listed the follo	ocument entitled "Side Rail wing guidelines:					
	1. All residents will be	e evaluated for the					
	appropriateness for u initiation on admission	se of bed rails prior to n.					
		ment will assess the need					
	for bed rails for mobili	ity. clude risk of entrapment.					
	4. Maintenance will fe	-					
	measuring rails.						
	5. Assure that the be	d's dimensions are sident's size and weight.					
		orporate the guidelines from					
	-	regards to Bed Safety.					
	The facility's Side Rai	il Rational Screen with an					
	assessment date of 0	8/03/2017 indicated side rail					
		endence of movement for					
	and decreased hearing	nt # 7's poor visual acuity ng complicated					
	communication and u	inderstanding. A fracture to					
	∣ the right ankle and de	ecline in overall function					

If continuation sheet Page 37 of 56

	CS FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		10. 0938-039	
	F CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · /	MPLETED	
		165453	B. WING		08/14/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 323	increased the risk of documented 1 staff p transfers and personal The Fall Risk Assess 03/31/2017 revealed or above indicated a During an interview of Resident # 6 sat in a observation of the up position) noted the m exceeded the 4.75 in failed to have any pa An observation on 08 found Resident #6 ou rails remained in the measurement of the 1 discovered the open horizontally by 7.75 in excess of the 4.75 in upper bed rails meas inches for the openin 2. An observation of 100 (bed 2), revealed exceeded the guidelin The middle bar openin horizontally and 17.5 3. According to the M resident #16 had a B indicated the residen short term memory d extensive assistance	falls. The plan of care berson needed to assist with al cares. ment completed on a score of 16. A score of 10 high risk for falls. on 07/31/2017 at 11:50 A.M., chair at bedside. An oper 1/2 rails (in the up iddle opening in the rail ches allowed. The bed rails dding in case of seizures. B/03/2017 at 12:00 P.M., it to lunch. Both upper 1/2 up position. A ruler middle part of the bed rail area to be 7.5 inches nches vertically which is in ches allowed. Both of the sured the same 7.5 by 7.75 g. an unoccupied bed in room d 2 metal rails which nes for bed rail openings. ing measured 7.5 inches inches vertically. MDS dated 07/14/2017, IMS score of 13 which t experienced intact long and	F 32				

Facility ID: IA0948

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I					FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	165453	B. WING			08/	14/2017
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	
PEARL VALLEY REHABILITATION	& HEALTHCARE CENTER O			1 E POLK ST ASHINGTON, IA 52353		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
 with bed mobility and safety. Staff should of Safety. Staff should of A Side Rail Assessme 08/03/2017 document safety awareness, porrequired frequent mor Recommendations ind for bed rails and to provide the length of the provide Observations of bed 2 11:30 A.M., found the the length of the room the wall did not meet to openings in a rail. Bot position. The middle inches horizontally an The bed rail toward the standards. The heating register more behind the bed and did placed flush against the from the wall with the measured 6.75 inches wall with the heat registrisk. 4. The Annual MDS did documented Resident and short term memore. 	ia, and depression. a revision date of taff to provide assistance use side rails (1/2 rails) for bserve for entrapment. ent completed on ted Resident # 15's lack of or trunk control, and hitoring by staff. cluded the resident's desire omote independence. Int period the resident c medications 7 of 7 days. 2 in room 306 on 03/2017 at bed to be horizontal along h. The bed 1/2 rail towards the 4.74 requirements for th rails were in the upright opening measured 7.5 d 7.75 inches vertically. le center of the room met an the length of the room id not allow the bed to be he wall. The bed's distance rail in the up position s. A bed placed against the ister could become a fire ated 05/26/2017 t # 16's difficulty with long	F	323			

Facility ID: IA0948

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	
		165453	B. WING			08/	14/2017
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O			01 E POLK ST VASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 323	Facility staff provide e personal cares and budisplayed no upper of Diagnoses included N seizure disorder, and disorder. The plan of care with 01/01/2017 directed f turning and reposition seizure precautions. The Side Rail Assess indicated Resident # in safety awareness a frequently at night. T rails. The Side Rail Assess documented the alter medications which re- and the need for frequ Observation of Bed # bilateral 1/2 rails in th displayed a middle ba 4.75 inch total for ope measured 7.5 inches vertically. Neither rail the diagnoses of seiz On 8/2/17, the facility Jeopardy by removing out of compliance, ed policy for monitoring a current and future resiseverity of the deficie	extensive assistance with all ed mobility. Resident #16 r lower extremity limitations. Non-Alzheimer's dementia, a a compulsive personality a revision date of facility staff to assist with hing in bed and provide ment of 08/03/2017 16 demonstrated alterations and needed to be monitored he facility removed the side ment of 05/28/2017 ed, poor trunk control, quired safety precautions, uent monitoring. 1 in room 306 noted e up position. Both rails ar which failed to meet the enings in a rail. The opening horizontally and 4.75 inches contained any padding for	F	323			

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	MEDICAID SERVICES				RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		TE SURVEY IPLETED
	165453	B. WING		0	8/14/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
PEARL VALLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST		
			WASHINGTON, IA 52353		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323 Continued From pag	e 40	F 32	3		
 tool, dated 6/30/17, I #19 included muscle diabetes. The MDS extensive assistance extensive assistance depended totally on and bathing, and dep transfers and toilet u resident did not walk listed the resident's E Mental Status) score intact cognition. A fall incident report, the nurse received a from the resident's ro resident needed help (Certified Nursing As CNA assisted the resident stated the nurse resp resident was on the f his/her left leg buckle resident was crying o my hip pop when I ro trying to adjust myse bed and then I rolled report stated the faci hospital. 	um Data Set) assessment isted diagnoses for Resident weakness, heart failure, and stated the resident required of 1 staff for dressing, of 2 staff for bed mobility, 1 staff for personal hygiene bended totally on 2 staff for se. The MDS stated the during the review period and BIMS (Brief Interview for as 15 out of 15, indicating dated 7/9/17, documented phone call at 10:51 p.m. bommate who stated the b. The nurse sent a CNA sistant) to the room and the sident to get his/her feet back 7 p.m., the nurse received a bom the resident's roommate ent needed help. The report bonded immediately and the floor beside the bed with ed under him/her. The but in pain and stated "I felt biled out of bed, I was just If when my legs fell out of out onto the floor." The lity sent the resident to the vised 11/3/16, documented d all 4 bed rails up.				

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/12/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		165453	B. WING		08/14/2017
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, Z	•
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICI	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 323	resident would be free the review date. The following intervention a. Be sure the resider and encourage the resider and encourage the resider from tipping forward c. Physical therapy to ordered and as neede The care plan lacked the resident from slip The facility schedule a.m. shift on 7/9/17 lis the entire shift and 1 2:00 a.m. onward. The CNA with her name con The facility policy on a stated full top and boo prohibited. A 7/10/17 hospital reg sustained a fracture of treated with an intram treat fractures of long During an interview on N CNA stated he wor from 6:00 p.m6:00 a CNA working in the u the building as well a was helping another of #19's call light was or called the facility on to O asked him to check	e of serious injury through care plan included the s: ent's call light is within reach esident to use it. a to wheelchair to prevent it o evaluate and treat as ed any interventions to prevent ping out of bed. for the 10:00 p.m 6:00 sted 1 nurse and 2 CNAs for additional CNA working from he schedule listed another rossed out. side rails, dated 6/28/17, ttom side rails were strictly	F 3	23	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		IO. 0938-039 E SURVEY	
AND PLAN OI	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED	
		165453	B. WING		08/14/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	hanging out of the be resident's legs back in requested body pillow then helped another in the resident when hea- thought was around of resident did not fall on bed when all 4 side ra- stated the resident re- was in the care plan a he/she did not have t During an interview of O RN(Registered Nut p.m6:00 a.m. on 7/9 she was sending ano emergency room whe at 10:51 p.m. from Re- stated Resident #19 in Staff N CNA to the re- him/her. After Staff N found the resident in out of the bed and he- repositioned him/her. received another pho- who stated the reside stated she heard Res- couldn't remember if after she arrived in the stated she went to the the resident on the flo- his/her legs buckled u told her he/she was the himself/herself and ro- resident stated his/her- followed. Staff O the	d. Staff N placed the n bed. The resident vs on each side. Staff N resident and Staff O found /she fell which Staff O 11:00 p.m. He stated the r have his/her legs out of the ails were on the bed. He quested all 4 side rails and it and the resident was upset he lower side rails anymore. n 7/13/17 at 7:01 a.m., Staff rse) stated she worked 6:00 0/17. She stated on 7/9/17, ther resident to the en she received a phone call esident #19's roommate who needed help. Staff O sent sident's room to help V returned, he told Staff O he bed with his/her legs coming e put his/her legs back and At 10:57 p.m., Staff O ne call from the roommate ent needed help. Staff O sident #19 screaming but this was on the phone or e resident's room and found bor on the buttocks with under him/her. The resident	F 323				

Facility ID: IA0948

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	IG	COMPLETED
		165453	B. WING _		08/14/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	IP CODE
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICI	ACTION SHOULD BE COMPLE TO THE APPROPRIATE DAT
F 323	Continued From page 43		F 3	23	
	bed but there was no) fall.			
	-	on 7/12/17 at 10:55 a.m., the stated Resident #19 fell			
		0:30-10:45 p.m. He/she			
		told him/her he/she was asked him/her to call for			
		pulled the call light but no			
		They both yelled for help and			
	Staff N CNA arrived a resident's feet back i	and helped place the n bed. Not long after that, the			
		e was falling out of bed			
	-	pulled the call light again but			
		st. The roommate then his/her cell phone and stated			
	-	and told him/her they were			
	busy with another en	nergency and he/she would			
		ommate stated the resident			
		nd he/she heard a "pop" ent started screaming. The			
		facility again on his/her cell			
	phone and he/she st	ated staff told him/her they			
		p calling. He/she stated			
		phone up so they could hear ng and stated they hung up			
		stated no one came for			
		ter the resident fell. The			
		she could not help the			
		get any of the staff to help he/she thought the facility			
		t's side rails sometime last			
	week and the resider	nt started to slip his/her legs			
	out of bed a couple t	mes before this fall.			
	-	on 7/12/17 at 11:20 a.m., the			
		ited she removed 4 side rails ue to "company policy. She			
	stated the owners di				

Facility ID: IA0948

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MAN SERVICES CAID SERVICES					FORM	APPROVED
ROVIDER/SUPPLIER/CLIA	1 ° <i>'</i>				(X3) DATE	SURVEY
165453	B. WING				08/ [,]	14/2017
	<u> </u>	STREET ADDRES	SS, CITY, STATE, ZIP CO	DDE		
LTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353					
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
 t who had them. 17 at 8:29 a.m., the Nursing) stated she the night of 7/9/17. all sometime after A did not show up. 7 at 11:04 a.m., the he resident's prior to the fall the to f bed. 7 at 11:20 a.m., Staff e resident had 4 side en the facility She stated after staff would walk by r feet dangling out of and help him/her put 7 at 9:16 a.m., the ted the Administrator e 2 bottom side rails it was a "state 7 at 11:36 a.m., the tated the facility rails and staff put a heet to keep him/her 	F 3	23				
	AID SERVICES COVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER: 165453 LTHCARE CENTER O T OF DEFICIENCIES BE PRECEDED BY FULL	AID SERVICES AID SERVICES (X2) MULTI A. BUILDIN 165453 B. WING	AID SERVICES ADVIDERSUPPLER/CLIA ENTIFICATION NUMBER: 165453 (X2) MULTIPLE CONSTRUCTION 165453 165453 16545 16545 16545 165 165 165 16	AD SERVICES RovidersupplierCLIA INTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 165453 B. WING LTHCARE CENTER O STREET ADDRESS, CITY, STATE, ZIP CC 601 E POLK ST WASHINGTON, IA 52353 I OF DEFICIENCIES BE PRECEDED BUY PULL THEYING INFORMATION) ID PREFIX PREFIX TAG PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCE Introduction of the fail the the night of 7/9/17. all sometime after A did not show up. F 323 7 at 11:20 a.m., the to foed. F 310 a.m., the to foed. 7 at 11:20 a.m., Staff e resident had 4 side en the facility She stated after staff would walk by r feet dangling out of a and help him/her put F 310 a.m., the tated the facility rails and staff put a heet to keep him/her 7 at 11:36 a.m., the tated the facility rails and staff put a heet to keep him/her F 310 a.m., the tated the facility rails and staff put a heet to keep him/her	AID SERVICES KONDERSUPPLENCLIA INTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING 165453 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 80 IE POLK ST WASHINGTON, IA 52353 TOF DEFICIENCIES 80 FRECEDED BY FULL TIFYING INFORMATION) D PREFIX TAG PRECEDED BY FULL TIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Noved the lower 2 t who had them. F 323 17 at 8:29 a.m., the Nursing) stated she the night of 7/9/17. F 323 18 sometime after A did not show up. F 321 7 at 11:04 a.m., the te resident had 4 side en the facility She stated after staff would walk by r feet dangling out of a and help him/her put F 7 at 11:36 a.m., the tated the facility 7	AID SERVICES OND NO NOTIFICATION NUMBER: ABUILING 165453 B. WING 165453 B. WING COMP STREET ADDRESS, CITY, STATE, ZIP CODE 601 E POLK ST WASHINGTON, IA 52353 TOF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DR Noved the lower 2 PREFIX TAG F 323

Facility ID: IA0948

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/12/2018 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		165453	B. WING			a	8/14/2017
NAME OF P	ROVIDER OR SUPPLIER	I		ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O	601 E POLK ST				
				W	ASHINGTON, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 323	required supervision a limited assistance of and extensive assista mobility, transfers, dru- bathing. The MDS re- walk during the review and only able to stabi- when moving from se- moving on and off the between bed and cha- stated the resident ha- injury since the last a resident's BIMS score moderately impaired During an observation resident laid in bed. The the resident and (open approximately bed and no floor mat- bed. A sign on the ou- the resident. During an observation resident to ask the the door closed, the s- resident. During an observation the resident. During an observation the resident wheeled unch. As he/she was CNA told the resident needed anything. Sta- the resident to the toi	assistance with eating, 1 staff for personal hygiene, ance of 1 staff for bed essing, toilet use, and evealed the resident did not w period and was not steady lize with staff assistance eated to standing position, e toilet, and transferring air or wheelchair. The MDS ad 2 falls resulting in no ssessment and listed the e as 8 out of 15, indicating cognition. In on 8/7/17 at 3:00 p.m., the No floor mat was present in call light was not in reach of In on 8/8/17 at 8:06 a.m., the Imost completely closed 1 inch). The resident lay in was present in front of the utside of the door directed e staff for assistance. With sign could not be seen by the In on 8/8/17, the resident's	F	323			

Facility ID: IA0948

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUT	TIPI F	CONSTRUCTION	(X3) DATE	0. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	· ,				PLETED	
		165453	B. WING			08/14/2017		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
PEARL VA	ALLEY REHABILITATION	& HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 323	Continued From page 46 wheeled himself/herself into his/her room and closed the door until it was open about 1 inch.		F	323				
	The resident stood up wheelchair, turned ar							
	Progress notes, date revealed a staff mem the floor and the resid							
		in the bathroom. The of leg, knee, and side hip						
	staff found the reside bathroom. The reside feet tangled and fell of revealed the resident listed the intervention	sistance and the installation						
		incident report documented e edge of the bed and slid stained no injury.						
	resident transferred to the wheelchair and th he/she slid out. The tear and the intervent	incident report stated the hemselves from the bed to he wheelchair rolled and resident sustained a skin tion listed to prevent a an anti-roll back device to the						
	wheelchair and chang require an assist of 1	ge the resident's transfers to staff for transfers. The ne resident went to the						
	revealed a staff mem	d 12/14/16 5:05 p.m., ber found the resident on t had hit his/her head against						

Facility ID: IA0948

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		165453	B. WING			08/	14/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
PEARL VA	ALLEY REHABILITATION	& HEALTHCARE CENTER O			01 E POLK ST VASHINGTON, IA 52353		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	the bed. The resident his/her neck down to him/her to the emerge Progress notes, dated documented the resid hospital at 7:00 p.m. v A 12/14/16 3:43 p.m. the resident sustained skin avulsion (tearing A 5/4/17 hospital repor from the toilet while si contusions (bruises). A 5/5/17 incident repor took themselves to th toilet onto the floor. The documented Residen the right shoulder. A 5/17/17 physician's had new and old com osteoporosis. The ph (lumbar sacral orthosis support the spine) and a DEXA scan (a scan and treatment for osted described the residen further compression for the resident should re- appointment in 6 wee The facility records la completion of a DEXA	complained of pain from the back so the facility sent ency room. d 12/15/16 at 2:09 a.m., lent returned from the with no new orders. hospital report documented d a superficial (not deep)) of the right great toe. ort revealed the resident fell leeping and sustained hip ort documented the resident e bathroom and fell off the he incident report t # 14 complained of pain in report revealed the resident pression fractures and hysician ordered an LSO is) brace (a brace used to d stated the resident needed measuring bone density) eoporosis. The report at as at substantial risk for ractures and documented eturn for a follow up ks. cked documentation of the A scan or the initiation of nt. The facility also had no cate the resident received	F	323			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/12/2018 APPROVED . 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		165453	B. WING		_	08/1	4/2017	
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE			
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		01 E POLK ST VASHINGTON, IA 5235	3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 323	resident on the floor b resident stated he/she and started shaking. came over to help but much he/she let go an floor. The report door sustained no injuries. A 5/23/17 radiology re had mild compression since 2/20/16, but dur radiology reported als compression fractures Progress notes, dated entry), revealed staff floor lying on the right complained of pain in the facility sent the re room. A hospital report, date resident experienced hip bruise and a mild A 5/25/17 fall incident resident attempted to bed without assistance incident report reveale abrasion to the left too the facility gave the re re-instructed the resident	ks. bort revealed staff found the by the bathroom door. The came out of the bathroom The resident's roommate the resident shook so ad the resident sat on the umented the resident eport indicated the resident a deformities, potentially new ation unknown. The o listed chronic s of variable severity. 1 5/24/17 at 1:35 a.m. (late found the resident the right hip, back and arm; sident to the emergency ed 5/24/17, revealed the a fall that resulted in a right	F 323		DEFICIENCY)			
		order documented an order apy and Physical Therapy						

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		165453	B. WING			08/	14/2017
	ROVIDER OR SUPPLIER	& HEALTHCARE CENTER O		60	TREET ADDRESS, CITY, STATE, ZIP CODE D1 E POLK ST /ASHINGTON, IA 52353		
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 323	the resident had diffic daily life, reduced upp functioning or muscle mobility (transfers) an screening recommend Therapy and Physical The facility lacked do began Occupational T Therapy. A 6/4/17 incident reports stated he/she went to quite make it back to revealed the resident documented the nurst utilize the call light an A 6/19/17 incident report the resident lying on the front of the wheelchai resident sustained no A 7/4/17 incident report the resident lying on the front of the wheelchai resident sustained no A 7/4/17 incident report the do urinate in the and fell on a mat near stated he/she tried to his/her balance. The care plan include entries:	ereening Form documented ulty performing activities of per/lower extremity weakness, difficulty with d was at risk for falls. The ded both Occupational Therapy for the resident Therapy or Physical of showed a nurse found the loor in front of the ort documented the resident the bathroom and didn't the the chair. The report sustained no injuries and e reminded the resident to d leave the door open. Nort documented staff found he right side on the floor in r. The report revealed the injuries.	F	323			

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 01/12/2018 RM APPROVED O. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		165453	B. WING			0	3/14/2017
NAME OF PI	ROVIDER OR SUPPLIER	1		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PEARL VA	LLEY REHABILITATION	I & HEALTHCARE CENTER O			1 E POLK ST		
				W	ASHINGTON, IA 52353		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	Continued From page	e 50	F 3	323			
		t required supervision to					
	7/17/17 The resident maximum assist of 1 6/15/17 Attempt to to						
	7/11/17 Be sure the reach.						
	7/11/17 Place a floor						
	A 8/3/17 Fall Risk As was at high risk for fa	sessment stated the resident alls.					
	CMA (Certified Medic	on 8/7/17 at 3 :30 p.m., Staff I cation Aide) stated the ire assistance with transfers.					
	-	on 8/8/17 at 8:15 a.m., Staff J ent went to the bathroom					
	-	on 8/8/17 the Director of ever saw the resident wear a					
	H CNA stated the res help with transfers bu	on 8/8/17 at 9:29 a.m., Staff sident sometimes needed ut sometimes transferred to the could help him/her.					
	ADON (Assistant Dire facility didn't have "m from orthopedics and the 6 week follow-up stated the local clinic and she didn't realized	on 8/8/17 at 11:45 a.m., the ector of Nursing) stated the nuch luck" obtaining a brace I stated Hospice canceled with the physician. She didn't carry out DEXA scans this until the resident She stated the resident had					

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CENTERS FOR MEDICARE & MEDICARD SERVICES OME NO.0938-0391 MID PLANOF CORRECTION MID PROVIDER OR SUPPLIANCE MOD MULTIPLE CONSTRUCTION MID OF CORRECTION MID MADE OF CORRECTION MID MADE OF CORRECTION MID OF CORRECTION 165453 B. WIND MID OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE 06142017 MID OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE 06142017 MID OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE 06142017 MID OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE 06142017 MID OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE 06142017 MID OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE 06142017 MID OF CORRECTIVE A WAST STREET PROCEED BY TULL PROTING 06142017 MID OF CORRECTIVE AND STREET OF DETICENCIES DREVE ADDRESS, CITY, STATE, 2P CODE 06142017 F 323 Continued From page 51 DLUIN PROTING WAST STREET PROCEED BY TULL PROTING WAST STREET PROCEED BY TULL 06142017 F 323 Continued From page 51 DLUIN PROTING WAST STREET PROCEED BY TULL PROTING WAST STREET PROCEED BY TULL F 323 F 323 Continued From page 51 DLUIN F 323 F 323 F 323 Durin		-					FORM): 01/12/2018 APPROVED	
INAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O STREET ADDRESS, CITY, STATE, 2P CODE IMAGE OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE IMAGE OF PROVIDER OF MAST REPRENDEND OF DEFICIENCIAL ID IMAGE OF PROVIDER STATEMENT OF DEFICIENCIAL ID IMAGE OF PROVIDER OF MAST REPRENDENT OF DEFICIENCIAL ID IMAGE OF PROVIDER OF MAST REPRENDENT OF DEFICIENCIAL ID IMAGE OF PROVIDER OF MAST REPRENDENT OF DEFICIENCIAL ID IMAGE OF PROVIDER OF MAST REPRENDENT OF DEFICIENCIAL ID IMAGE OF PROVIDER OF MAST REPRENDENT OF DEFICIENCIAL ID IMAGE OF PROVIDER OF MAST REPRENDENT OF DEFICIENCIAL ID IMAGE OF PROVIDER OF MAST REPRENDENT OF DEFICIENCIAL ID IMAGE OF PROVIDER OF MAST REPRENDENT OF DEFICIENCIAL ID IMAGE OF PROVIDER OF MAST REPRENDENT OF DEFICIENCIAL ID IMAGE OF PROVIDER OF MAST REPRENDENT OF DEFICIENCIAL OF DEFICIENCY ID IMAGE OF PROVIDER OF MAST REPRENDENT OF DEFICIENCIAL ID IMAGE OF REPUT ID ID IMAGE OF REPUT ID ID IMAGE OF REPUT ID ID IMAGE OF REPUT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY		
BIT E POLK ST WASHINGTON, IA 2333 PREFIX TWA SUMMARY STATEMENT OF DEFICIENCIES INCOMENTIAL ACTION SOLUDES INCOMENTIAL ACTION SOLUDES INCOMENTIAL REGULTION OF LSC DENTIFYING INFORMATION) D PACE TWASHINGTON, IA 2333 F 323 Continued From page 51 During an interview on 8/8/17 at 11:45 a.m., the Regulation of 5/25/17, but did not begin therapy. Sub stated Hospice "probably dropped him". F 323 During an interview on 8/8/17 at 11:00 a.m., the Dig in therapy. Sub stated Hospice "probably dropped him". F 323 During an interview on 8/8/17 at 11:00 a.m., the Director of Nursing stated staff should dreft the resident was likely to fall again and stated staff did not always communicate new fall interventions to her so she could add them to the care plan. F 363 During an interview on 8/8/17 at 11:36 a.m., the Director of Nursing stated staff should attempt to take the resident to be abtroom. She stated the resident was likely to fall again and stated staff did not always communicate new fall interventions to her so she could add them to the care plan. F 363 State F 363 State State (c)(1) Menus and nutitional needs of residents in accordance with established national guidelines; (c)(2) Be prepared in advance; (c)(3) Be followed; (c)(4) Reflect, based on a facility's reasonable efforts, the religicut, cultural and ethnic needs of F 363			165453	B. WING			08/ [,]	14/2017	
PERALVALLEY REHABILITATION & HEALTHCARE CENTER 0 WASHINGTON, IA 52353 (X4)/10 PREFIX TAG SUMMARY SIXTEMENT OF DEFICIENCIES (EACH DEFICIENCIES) RECULATORY OR LSC DENTIFYING INFORMATION) D PREFIX TAG D PROVIDER YEAR CORRECTIVE AS IDENTIFYING INFORMATION) D PREFIX TAG D PREFIX PROVIDER YEAR CORRECTIVE AS IDENTIFYING INFORMATION) D PREFIX TAG D PROVIDER YEAR CORRECTIVE AS IDENTIFYING INFORMATION) CORRECTIVE PREFIX PROVIDER YEAR CORRECTIVE AS IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER YEAR CORRECTIVE AS IDENTIFYING INFORMATION) CORRECTIVE PROVIDER YEAR CORRECTIVE AS IDENTIFYING INFORMATION) PREFIX PROVIDER YEAR CORRECTIVE AS IDENTIFYING INFORMATION PROVIDER THE TREE INFORMATION INFORMATION INFORMATION PROVIDER YEAR CORRECTIVE AS IDENTIFYING INFORMATION P	NAME OF PF	OVIDER OR SUPPLIER				TATE, ZIP CODE			
Precisiv TxG (EACH CORRECTION VALUE THE PRECIDED BY FULL RECULZTORY OR LSG LIBENTIFING INFORMATION) PRETIX TxG CACH CORRECTIVE ACTION SHOULD BE CROSS-BEREREDUCED TO HEAPROPHIATE COMMENTION F 323 Continued From page 51 During an interview on 8/3/17 at 11:45 a.m., the received a therapy evaluation on 5/25/17, but did not begin therapy. She stated Hospice "probably dropped him". F 323 During an interview on 8/3/17 at 11:00 a.m., the MDS Coordinator stated staff should offer the resident assistance with transfers. She agreed the resident was likely to fall again and stated staff did not always communicate new fall interventions to her so she could add them to the care plan. F 363 During an interview on 8/3/17 at 11:36 a.m., the Director of Nursing stated staff should attempt to take the resident to the bathroom. She stated the resident had a main the future. Work on changing the care plans in the future. Work on changing the care plans in the future. (c)(1) Meet the nutritional adequacy. Menus must! (c)(1) Meet the nutritional adequacy. Menus must! (c)(2) Be prepared in advance; (c)(3) Be followed; (c)(4) Reflect, based on a facility's reasonable effolts, the religious, cultural and ethnic needs of F 363	PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O			53			
During an interview on 8/8/17 at 11:45 a.m., the Regional Vice President stated the resident received a therapy evaluation on 5/25/17, but did not begin therapy. She stated Hospice "probably dropped him". During an interview on 8/9/17 at 11:00 a.m., the DisCoordinator stated staff should offer the resident assistance with transfers. She agreed the resident was likely to fall again and stated staff did not always communicate new fall interventions to her so she could add them to the care plan. During an interview on 8/8/17 at 11:36 a.m., the Director of Nursing stated staff should attempt to take the resident to the bathroom. She stated the resident had a mat but staff kept removing it from the resident to the bathroom. She stated the resident president premoving it from the RUNS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED CFR(s): 483.60(c)(1)(-17) (c) Menus must- (c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; (c)(2) Be prepared in advance; (c)(2) Be prepared in advance; (c)(4) Reflect, based on a facility's reasonable (c)(4) Reflect	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BE INCED TO THE APPROPRIA		COMPLETION	
	F 363	During an interview or Regional Vice Preside received a therapy ev not begin therapy. Sh dropped him". During an interview or MDS Coordinator stat resident assistance w the resident was likely staff did not always co interventions to her so care plan. During an interview or Director of Nursing stat take the resident to th resident had a mat but the room and reported work on changing the MENUS MEET RES M ADVANCE/FOLLOWE CFR(s): 483.60(c)(1)- (c) Menus and nutrition Menus must- (c)(1) Meet the nutrition accordance with estat (c)(2) Be prepared in a (c)(3) Be followed; (c)(4) Reflect, based of efforts, the religious, of	n 8/8/17 at 11:45 a.m., the ent stated the resident aluation on 5/25/17, but did he stated Hospice "probably in 8/9/17 at 11:00 a.m., the ted staff should offer the with transfers. She agreed y to fall again and stated communicate new fall to she could add them to the in 8/8/17 at 11:36 a.m., the ated staff should attempt to be bathroom. She stated the at staff kept removing it from d the facility was going to care plans in the future. NEEDS/PREP IN ED (7) onal adequacy.						

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		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		165453	B. WING			08/	14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
PEARL V	ALLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353			
(X4) ID PREFIX TAG				PROVIDER'S PL (EACH CORRECTI) CROSS-REFERENCE DEF		(X5) COMPLETION DATE	
F 363	from residents and re (c)(5) Be updated per (c)(6) Be reviewed by other clinically qualifie nutritional adequacy; (c)(7) Nothing in this p construed to limit the personal dietary choid This REQUIREMENT by: Based on observatio policy review, the fact regular diets (47 resid potato wedges to ens equivalents as 4 ound those on pureed diet census of 49 resident Findings include: During an observation pureed process on 08 Staff L (dietary cook) would be getting 4 out instead of the potato Observations of the n the regular diets woul for 1 portion of potato the noon meal service 08/02/2017, Staff H p potato using tongs, (r each plate for the reg	sident groups; iodically; the facility's dietitian or ed nutrition professional for and paragraph should be resident's right to make ces. is not met as evidenced n, staff interview, and facility lity failed to provide those on dents) with 4 ounces of ure the same nutritional ces of mashed potatoes for s. The facility reported a s.	F 3	63			

Facility ID: IA0948

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:			PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		165453	B. WING			08/1	4/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O		601 E POLK ST WASHINGTON, IA 52353			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PL (EACH CORRECTI) CROSS-REFERENCE DEF		(X5) COMPLETION DATE	
F 363 F 465 SS=F	3 potato wedges weig The use of a 4 ounce wedges would provide nutritional equivalent. The Daily Spreadshee diets outlined, 4 ounce he pureed diets and o regular diets. SAFE/FUNCTIONAL/ E ENVIRON CFR(s): 483.90(i)(5) (i) Other Environment The facility must prov sanitary, and comforta residents, staff and the (5) Establish policies, applicable Federal, Si regulations, regarding and smoking safety the non-smoking resident This REQUIREMENT by: Based on observation interview, the facility for and functional environ a census of 46 reside Findings include: 1. During the environ 12:04 p.m., the follow	<pre>ghed 1.5 ounces. spoodle for the potato e a more consistent et for week 2 with the varied es of mashed potatoes for only 3 potato wedges for //SANITARY/COMFORTABL tal Conditions ide a safe, functional, able environment for re public. in accordance with tate, and local laws and g smoking, smoking areas, nat also take into account is. i is not met as evidenced n, record review, and failed to maintain a clean ment. The facility reported</pre>	F 3	63	ICIENCY)		
	entrance was not sec was loose and bent.	ured tightly to the door and					

Facility ID: IA0948

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		165453	B. WING _			08/	14/2017
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL VA		& HEALTHCARE CENTER O			01 E POLK ST VASHINGTON, IA 52353		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 465 F 497 SS=D	 b. The tile in the show a black mold-like subsi in the grout. During an observation shower room in the 10 mold-like substance of the shower room. The undated facility h schedule directed sta and walls and utilize a necessary. During an interview of Administrator provide facility cleaning sched showers was a regula duties. NURSE AIDE PERFO INSERVICE CFR(s): 483.35(d)(7) (d)(7) Regular In-Server The facility must com of every nurse aide at months, and must pro- education based on the reviews. In-service the requirements of §483 This REQUIREMENT by: Based on record revifacility failed to assure Nursing Assistants reviews. 	wer room in the 600 Hall had stance in between each tile n on 8/3/17 at 9:00 a.m., the 00 Hall had a black on the tiles and the walls of ousekeeping daily cleaning ff to spray the shower floors a long-handled brush if n 8/3/17 at 11:30 a.m., the d the survey team with the dule and stated cleaning the ar part of the housekeeping DRM REVIEW-12 HR/YR vice Education plete a performance review t least once every 12 ovide regular in-service he outcome of these aining must comply with the .95(g). is not met as evidenced iew and facility interview, the e that 4 of 10 Certified viewed attended 12 on a yearly basis. The		465			

Facility ID: IA0948

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/12/2018 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE	
		165453	B. WING			_	08/	14/2017
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
PEARL VA	LLEY REHABILITATION	& HEALTHCARE CENTER O			01 E POLK ST /ASHINGTON, IA 5235	3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID			PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRE) CROSS-REFEREI	CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 497	Continued From page	55	F	497	1			
	Findings include:							
		employed Certified Nursing d all 12 of the mandatory y the facility.						
	Staff K attended only inservices in 2016.	3 of the 12 mandatory						
	Staff C attended 6 of inservices in 2016.	the 12 mandatory						
	Staff Q attended only disservices in 2016.	2 of the 12 mandatory						
	Staff J attended 10 ou inservices in 2016.	ut of 12 mandatory						

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