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PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Amended after IDR-IC. Correction Date_____ The following deficiencies relate to the annual recertification and investigation of complaints 69642-C, 69219-C, 69148-C, 69153-C, and 68577-C and facility reported incident 69244-I, conducted on 7/31/17 to 8/010/17. Complaint 69642-C, 69219-C, 69148-C, and 69153-C and facility reported incident 69244-I were substantiated. Complaint 68577-C was not substantiated. See code of Federal Regulations (42CFR) Part 482, Subpart B.	F 000		
F 156 SS=D	NOTICE OF RIGHTS, RULES, SERVICES, CHARGES CFR(s): 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/28/2017

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(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -

(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State

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and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for

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information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:

(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon

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admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident

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before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.

(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.

(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.

v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:

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F 156	Continued From page 6 Based on record review and interview, the facility failed to provide the appropriate notices of Medicare coverage coming to an end for 1 of 3 residents reviewed. (Resident # 13) The facility reported a census of 46 residents. Findings: 1. Facility documentation revealed Resident #13 received Medicare benefits for skilled services starting 9/19/16 and ending 10/5/16. The resident's Skilled Nursing Facility Advance Beneficiary Notice revealed the facility notified the resident of services ending on 10/5/16. The notice lacked documentation the facility notified the resident of the services ending 48 hours prior to the last day of services. During an interview on 8/1/17 at approximately 10:43 a.m., the Regional Vice President stated the facility should carry out notifications 48 hours prior to the last date of skilled services.	F 156		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 157		

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mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview, and facility policy, the facility failed to notify the Physician concerning a significantly low blood

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sugar for 1 out of 4 resident's reviewed with diabetes (Resident #17). The facility reported a census of 49 residents.

Findings include:

The Admission Minimum Data Set (MDS) with an assessment reference date of 06/13/2017 revealed a Brief Interview for Mental status (BIMS) score of 8 which indicated moderately impaired long and short term memory issues. Resident # 17 received 7 insulin injections and 1 change in the Physician's orders for insulin during this assessment period. Resident #17's diagnosis included a transient ischemic attack (TIA) and an essential tremor.

The plan of care initiated on 06/14/2017 included a diagnosis of diabetes mellitus. The plan directed licensed staff to administer medication for diabetes as ordered by the Physician, assess for hypo or hyperglycemia (low or high blood sugars), and to check the blood glucose levels 4 times a day.

Review of the June 2017 Treatment Administration Record (TAR) revealed Resident # 17 admitted on 06/02/2017, revealed low blood sugars (finger sticks to check sugar levels) on June 5, 6, 9, and 11. On 06/05/2017 staff documented the blood sugar levels on the TAR as 43 for 11:00 A.M., and on 06/09/2017 at 4:30 P.M., the blood sugar level was 67. Blood sugars within normal range usually vary between 90 and 110.

The medical record failed to contain any information that indicated staff notified the Physician of the low blood sugars.

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On June 10 and 11, the TAR documentation indicated the nurse held the insulin at 4:30 P.M. on 06/10/2017 for a blood sugar level of 44 and held the insulin again at 06:45 A.M. (for 125) and 04:30 P.M. (for 119) on 06/11/2017. The facility failed to contact the Physician to provide notification of the low blood sugars or their decision to hold the insulin.

In an interview on 08/09/2017 at 1:30 P.M., Staff E (Registered Nurse) verbalized not recalling what happened on June 10 and 11, but did remember the blood sugar level the night before had been low. She failed to call the Physician, but held the insulin because of the low blood sugar the night before. She stated not knowing what the facility policy guidelines directed staff to do for a low blood sugar.

In an interview on 08/09/2017 at 02:20 P.M., the Director of Nursing stated being aware of the low blood sugar and the insulin being held over June 9, 10 and 11. The DON reported calling the Physician to report the incidents. The Physician gave orders to call for blood sugars under 70 and over 350.

During an interview at 20:30 P.M. on 08/09/2017, the Nurse Practitioner verbalized the nurse should have called the Physician on the low blood sugar and held insulin on June 9-11. The Nurse Practitioner stated nursing needed an order to hold the insulin, and low blood sugars needed to be reported.

The undated Blood Glucose Monitoring Protocol procedure directed licensed staff to notify the Physician if the finger stick for blood sugars ran less than 70 and greater than 350.

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F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 279		

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findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to create and follow interventions to prevent a fall for 1 of 2 residents reviewed with a major injury (Resident #19) and failed to add facility established fall interventions to the care plan and follow interventions listed on the existing care plan in order to prevent future falls for 1 of 6 residents with a history of falls (Resident #14). The facility reported a census of 46 residents.

Findings include:

1. The MDS (Minimum Data Set) assessment tool, dated 6/30/17, listed diagnoses for Resident #19 that included muscle weakness, heart failure, and diabetes. The MDS stated the resident

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required extensive assistance of 1 staff for dressing, extensive assistance of 2 staff for bed mobility, depended totally on 1 staff for personal hygiene and bathing, and depended totally on 2 staff for transfers and toilet use. The MDS stated the resident did not walk during the review period and listed the resident's BIMS(Brief Interview for Mental Status) score as 15 out of 15, indicating intact cognition.

A fall incident report, dated 7/9/17, stated the nurse received a phone call at 10:51 p.m. from the resident's roommate who stated the resident needed help. The nurse sent a CNA(Certified Nursing Assistant) to the room and the CNA assisted the resident to get his/her feet back into the bed. At 10:57 p.m., the nurse received a second phone call from the resident's roommate who stated the resident needed help. The report stated the nurse responded immediately and the resident was on the floor beside the bed with his/her left leg buckled under him/her. The resident was crying out in pain and stated "I felt my hip pop when I rolled out of bed, I was just trying to adjust myself when my legs fell out of bed and then I rolled out onto the floor." The report stated the facility sent the resident to the hospital.

A care plan entry, revised 11/3/16, documented the resident preferred all 4 bed rails up.

A care plan entry, revised 4/13/16, stated the resident was at high risk for falls and the resident would be free of serious injury through the review date. The care plan included the following interventions:

a. Be sure the resident's call light is within reach

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and encourage the resident to use it.
b. Front wheelie bars to wheelchair to prevent it from tipping forward
c. Physical therapy to evaluate and treat as ordered and as needed

The care plan lacked any interventions to prevent the resident from slipping out of bed.

The facility policy on side rails, dated 6/28/17, stated full top and bottom side rails were strictly prohibited.

During an interview on 7/13/17 at 5:05 a.m., Staff N CNA stated he worked at the facility on 7/9/17 from 6:00 p.m.-6:00 a.m. He stated aside from a CNA working in the unit, he was the only CNA in the building as well as the nurse. He stated he was helping another resident when Resident #19's call light was on. Resident #19's roommate called the facility on the phone for help and Staff O asked him to check on him/her. When he entered the room, both of the resident's legs were hanging out of the bed. Staff N placed the resident's legs back in bed. The resident requested body pillows on each side. Staff N then helped another resident and Staff O found the resident when he/she fell which Staff O thought was around 11:00 p.m. He stated the resident did not fall or have his/her legs out of the bed when all 4 side rails were on the bed. He stated the resident requested all 4 side rails and it was in the care plan and the resident was upset he/she did not have the lower side rails anymore.

During an interview on 7/12/17 at 10:55 a.m., the resident's roommate stated Resident #19 fell sometime between 10:30-10:45 p.m. He/she stated she thought the facility removed the

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resident's side rails sometime last week and the resident started to slip his/her legs out of bed a couple times before this fall.

During an interview on 7/12/17 at 11:20 a.m., the MDS Coordinator stated she removed 4 side rails from the care plan due to "company policy". She stated the owners directed that residents could not have all 4 side rails because it was a restraint. She stated maintenance removed the lower 2 side rails from every resident who had them.

During an interview on 8/8/17 at 11:04 a.m., the resident's daughter stated the resident's roommate told her 2-3 days prior to the fall the resident had been falling out of bed.

During an interview on 8/8/17 at 11:20 a.m., Staff P CNA stated at one time the resident had 4 side rails and was very angry when the facility removed 2 of the side rails. She stated after he/she had only 2 side rails, staff would walk by his/her room and see his/her feet dangling out of bed and would need to go in and help him/her put them back.

During an interview on 8/9/17 at 9:16 a.m., the Maintenance Supervisor stated the Administrator instructed him to remove the 2 bottom side rails from some beds and stated it was a "state mandated decision."

During an interview on 8/8/17 at 11 :36 a.m., the DON (Director of Nursing) stated the facility removed the residents side rails and staff put a pillow under the resident's sheet to keep him/her from rolling out of bed.

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2. The MDS assessment tool, dated 5/26/17, listed diagnoses for Resident #14 included muscle weakness, schizophrenia, and coronary artery disease. The MDS stated the resident required supervision assistance with eating, limited assistance of 1 staff for personal hygiene, and extensive assistance of 1 staff for bed mobility, transfers, dressing, toilet use, and bathing. The MDS stated the resident did not walk during the review period and was not steady and only able to stabilize with staff assistance when moving from seated to standing position, moving on and off the toilet, and transferring between bed and chair or wheelchair. The MDS stated the resident had 2 falls resulting in no injury since the last assessment and listed the resident's BIMS score as 8 out of 15, indicating moderately impaired cognition.

During an observation on 8/7/17 at 3:00 p.m., the resident lay in bed. No floor mat was present in front of the bed. The call light was not in reach of the resident.

During an observation on 8/8/17 at 8:06 a.m., the resident's door was almost completely closed (open approximately 1 inch). The resident lay in bed and no floor mat was present in front of the bed. A sign on the outside of the door directed the resident to ask the staff for assistance. With the door closed, the sign could not be seen by the resident.

During an observation on 8/8/17, the resident's door was completely closed.

During an observation on 8/8/17 at 11:42 a.m., the resident wheeled himself/herself back from lunch. As he/she was entering the room, Staff H

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CNA told the resident to pull the call light if he/she needed anything. Staff H did not offer to assist the resident to the toilet or assist the resident with anything in his/her room. The resident then wheeled himself/herself into his/her room and closed the door until it was open about 1 inch. The resident stood up by himself/herself from the wheelchair, turned around, and sat on the bed.

Progress notes, dated 11/12/16 5:53 a.m. documented a staff member found the resident on the floor and the resident stated he/she fell after trying to turn around in the bathroom. The resident complained of leg, knee, and side hip pain.

A 12/6/16 10:40 a.m. incident report stated the staff found the resident lying on the floor of the bathroom. The resident stated he/she got his/her feet tangled and fell on the buttocks. The report stated the resident sustained no injuries and listed the interventions of encouraging the resident to ask for assistance and the installation of grab bars in the bathroom.

A 12/14/16 3:00 a.m. incident report stated the resident sat on the edge of the bed and slid onto the floor and sustained no injury.

A 12/14/16 3:00 p.m. incident report stated the resident transferred self from bed to wheelchair and the wheelchair rolled and he/she slid out. The resident sustained a skin tear and the intervention listed to prevent a recurrence was anti-roll back to wheelchair and to make the resident an assist of 1 staff for transfers. The report documented the resident went to the emergency room.

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Progress notes, dated 12/14/16 5:05 p.m., stated a staff member found the resident on the floor and the resident hit his/her head against the bed and complained of pain from his/her neck down to the back. The incident report revealed the resident went to the emergency room.

A 12/14/16 3:43 p.m. hospital report stated the resident had a superficial (not deep) skin avulsion (tearing) of the right great toe.

A 5/4/17 hospital report revealed the resident fell from the toilet while sleeping and sustained hip contusions (bruises).

A 5/5/17 incident report revealed the resident took themselves to the bathroom, fell off the toilet onto the floor, and complained of pain in the right shoulder.

A 5/22/17 incident report documented staff found the resident on the floor by the bathroom door. The resident stated he/she came out of the bathroom and started shaking. The resident's roommate came over to help but the resident shook so much he/she let go and the resident sat down on the floor. The report revealed the resident sustained no injuries.

A 5/23/17 radiology report revealed the resident had mild compression deformities which were potentially new since 2/20/16, but duration unknown. The report documented chronic compression fractures of variable severity.

Progress notes, dated 5/24/17 at 1:35 a.m. (late entry), documented staff found the resident on the floor lying on the right side. The resident complained of pain in the right hip, back and arm,

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so the facility sent the resident to the emergency room.

A hospital report, dated 5/24/17, stated the resident had a fall with a right hip bruise and a mild closed head injury.

A 5/25/17 fall incident report revealed the resident tried to get out of bed without assistance, slid to the floor, and sustained an abrasion to the left toe. The report documented the facility gave the resident a high/low bed, re-instructed the resident to use the call light, and placed a mat on the floor in front of the bed.

A 5/25/17 physician's order displayed an order for Occupational Therapy and Physical Therapy to evaluate and treat.

A 5/25/17 Therapy Screening Form revealed the resident had difficulty performing activities of daily life, reduced upper/lower extremity functioning or muscle weakness, difficulty with mobility (transfers), and was at risk for falls. The screening recommended both Occupational Therapy and Physical Therapy for the resident.

The facility could not provide documentation that indicated the resident began Occupational Therapy or Physical Therapy.

A 6/4/17 incident report revealed a nurse found the resident lying on the floor in front of the wheelchair. The resident stated he/she went to the bathroom and didn't quite make it back to the the chair. The report revealed the resident sustained no injuries and also revealed the nurse reminded the resident to utilize the call light and leave the door open.

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A 6/19/17 incident report stated staff found the resident lying on the right side on the floor in front of the wheelchair. The report stated the resident sustained no injuries.

A 7/4/17 incident report documented the resident tried to urinate in the trash, lost his/her balance, and fell on a mat near the bed. The resident stated he/she tried to go to the bathroom and lost his/her balance.

The care plan included the following dated entries:

4/28/17 The resident is able to toilet himself/herself.
4/28/17 The resident required supervision to transfer.
7/17/17 The resident required moderate to maximum assist of 1 staff with transfers.
6/15/17 Attempt to toilet before/after meals.
7/11/17 Be sure the resident's call light is within reach.
7/11/17 Place a floor mat beside the bed.

The care plan lacked clarity as to whether or not the resident required assistance with transfers. The care plan also lacked documentation that directed the staff to leave the resident's door open, as written as an intervention on a fall incident report.

A 8/3/17 Fall Risk Assessment assessed the resident as at high risk for falls.

During an interview on 8/7/17 at 3:30 p.m., Staff I CMA (Certified Medication Aide) stated the resident did not require assistance with transfers.

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F 279	Continued From page 20 During an interview on 8/8/17 at 8:15 a.m., Staff J CMA stated the resident went to the bathroom independently. During an interview on 8/8/17 at 9:29 a.m., Staff H CNA stated the resident sometimes needed help with transfers but sometimes transferred to his/her chair before she could help him/her. During an interview on 8/9/17 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. During a 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 room. She stated the facility was going to work on changing the care plans in the future.	F 279		
F 281 SS=E	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and	F 281		

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interview, the facility failed to carry out physician's orders for 3 of 16 residents reviewed (Resident #4, #14, and #17). The facility reported a census of 46 residents.

Findings include:

1. The MDS (Minimum Data Set) assessment tool, dated 7/18/17, listed diagnoses for Resident #4 included heart failure, asthma, chronic obstructive pulmonary disease, or chronic lung disease, and obesity. The MDS stated the resident required extensive assistance of 1 staff for personal hygiene, extensive assistance of 2 staff for bed mobility and dressing, depended totally on 1 staff for bathing, and depended totally on 2 staff for transfers and toilet use. The MDS stated the resident required oxygen therapy and listed the resident's BIMS (Brief Interview for Mental Status) score as 15 out of 15, indicating intact cognition.

During an observation on 7/31/17 at 3:45 p.m., the resident lay in bed and utilized oxygen via nasal cannula. The oxygen concentrator read 3.5 liters.

During an observation on 8/1/17 at 1:54 p.m., the resident lay in bed and utilized oxygen via nasal cannula. The oxygen concentrator read 2.5 liters.

During an observation on 8/2/17 at 7:12 a.m., the resident lay in bed and utilized oxygen via nasal cannula. The oxygen concentrator read slightly over 3 liters.

Admission orders, dated 6/23/17, displayed an order for 2 liters continuous oxygen per nasal cannula.

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During an interview on 8/2/17 at approximately 3:00 p.m., the ADON (Assistant Director of Nursing) stated she would begin a new system of labeling each oxygen machine to inform staff of the appropriate setting for each resident.

2. The MDS assessment tool, dated 5/26/17, listed diagnoses for Resident #14 included muscle weakness, schizophrenia, and coronary artery disease. The MDS stated the resident required supervision assistance with eating, limited assistance of 1 staff for personal hygiene, and extensive assistance of 1 staff for bed mobility, transfers, dressing, toilet use, and bathing. The MDS stated the resident did not walk during the review period and was not steady and only able to stabilize with staff assistance when moving from seated to standing position, moving on and off the toilet, and transferring between bed and chair or wheelchair. The MDS stated the resident had 2 falls resulting in no injury since the last assessment and listed the resident's BIMS score as 8 out of 15, indicating moderately impaired cognition.

A 5/17/17 physician's report stated the resident had new and old compression fractures and osteoporosis. The physician ordered a LSO (lumbar sacral orthosis) brace (a brace used to support the spine) and stated the resident needed a DEXA scan (a scan measuring bone density) and treatment for osteoporosis. The report stated the resident was at substantial risk for further compression fractures and stated the resident should return for a follow up appointment in 6 weeks.

The facility records lacked documentation of the

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completion of a DEXA scan or the initiation of osteoporosis treatment and lacked documentation the resident received a LSO brace or attended a follow up appointment in 6 weeks.

A 5/25/17 physician's order displayed an order for Occupational Therapy and Physical Therapy to evaluate and treat.

A 5/25/17 Therapy Screening Form documented the resident had difficulty performing activities of daily life, reduced upper/lower extremity functioning or muscle weakness, difficulty with mobility (transfers) and was at risk for falls. The screening recommended both Occupational Therapy and Physical Therapy for the resident.

The facility lacked documentation the resident began Occupational Therapy or Physical Therapy.

During an interview on 8/8/17 the Director of Nursing stated she never saw the resident wear a brace.

During an interview on 8/8/17 at 11:45 a.m., the ADON (Assistant Director of Nursing) stated the facility didn't have "much luck" obtaining a brace from orthopedics and stated Hospice canceled the 6 week follow-up with the physician. She stated the local clinic didn't carry out DEXA scans and she didn't realize this until the resident arrived at the clinic. She stated the resident had an x-ray in lieu of the DEXA scan.

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 the resident did not begin therapy. She stated

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Hospice "probably dropped him".
3. The Initial Minimum Data Set (MDS) with an assessment reference date of 06/13/2017 revealed a Brief Interview for Mental status (BIMS) score of 8 which indicated moderately impaired long and short term memory issues. Resident # 17 received limited assistance with toilet use and personal hygiene. An indwelling urinary catheter provided release of urine from the body into an external bag which staff took care of. Diagnoses included a transient ischemic attack (TIA), an essential tremor, and muscle weakness.

The plan of care initiated on 06/14/2017 included additional diagnoses of diabetes mellitus, atrial fibrillation, diabetes mellitus, and major depression. The plan directed staff to keep the catheter tubing below bladder level when doing cares, monitor and document urine output, and assess for pain.

On 06/03/2017, a New Orders on Current Resident's sheet displayed an order for a size 16 French urinary catheter. The Physician never signed the order sheet. The most current Physician's Order Sheet signed 07/30/2017 signed by the Physician, failed to document an order for an indwelling urinary catheter.

The August Treatment Administration Sheet (TAR) failed to contain an order for the indwelling urinary catheter.

Observations of Resident # 17 on August 7, 2017 at 10:45 A.M. and 4:50 P.M., August 8, 2017 at 8:00 A.M. and at 2:25 P.M., revealed the indwelling urinary catheter remained in place.

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F 281	Continued From page 25 An observation on August 7, 2017 at 11:17 A.M., Staff K and Staff M (Certified Nursing Assistants) entered Resident # 17's room, closed the door, washed their hands and donned gloves. Staff K explained the cares they would be completing for the resident. An observation of the cares revealed an indwelling urinary catheter for Resident # 17. During an interview on 07/09/2017 at 3:40 P.M., the Assistant Director of Nursing stated the order for the Foley catheter must have missed being placed on the 07/31/2017 Physician's Order Sheet and TAR. No current order other than the unsigned order on 06/03/2017 could be located.	F 281		
F 314 SS=G	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 314		

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Based on observation, record review, and interviews the facility failed to prevent two pressure sores for 1 of 1 residents reviewed with pressure sores (Resident #2). The facility reported a census of 46 residents.

Findings include:

The Admission Minimum Data Set (MDS) dated 6/20/17 documented Resident #2 scored a 3 out of 15 for the brief interview for mental status (severely impaired cognitive skills for daily decision making). The MDS documented the resident required total assistance of two staff for bed mobility, transfers, and dressing. The MDS also documented limitation in range of motion for one side of lower and upper extremity. The MDS the resident had diagnoses that included cerebral vascular accident (stroke) and an irregular heart rhythm. The MDS documented the resident had a pressure reducing device for the bed and chair. The MDS documented the resident had been on a repositioning program, and had applications of medications for skin treatments other than to the feet.

The Nurses Progress Note dated 6/13/17 at 3:15 p.m. documented the resident had inner elbow needle stick areas, the coccyx area had scabbed areas present, the right buttock had a 1.5 centimeter (cm) by 2 cm area, and the left buttock had two, 0.5 cm by 0.5 cm circular areas on top and a 2 cm by 1 cm area on the bottom. The documentation lacked measurements of the coccyx area. The resident's record lacked documentation of further assessment to the areas on the buttocks, and the inner elbow needle stick areas. The coccyx are documentation resumed on 6/28/17.

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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.

The Admission Nutrition Assessment Note dated 6/16/17 at 4:11 p.m. lacked documentation of any skin related issues.

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 7/14/17 documented the resident's had a coccyx wound which was closed upon admission, but it had since reopened.

The Nurses Progress Noted dated 6/16/17 at 1:42 p.m. documented the resident defecated green, mushy stool.

The Nurse's Progress Note dated 6/18/17 at 4:19 p.m. documented the nurse noticed the resident's feet were very dry and and lotion applied. At that time, the nurse noted the resident's left heel had been very spongy. The nurse notified the

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physician and family. The note did not indicate the nurse notified the wound nurse.

A Therapy Recommendation Note dated 6/22/17 at 6:43 p.m. directed staff to use a Hoyer for transfers and to position the resident in a wheelchair for two hours in the morning and two hours in the afternoon. The Note also directed staff to float heels at all times and use boots when in the wheelchair.

The Skin Wound Note dated 6/26/17 7:11 a.m. documented the resident had a 1.6 cm by 0.6 cm open area to the intercalate crease (area had previously been open at hospital prior to admission here), which was without drainage, odor, or other signs or symptoms of infection. The Note directed staff to apply barrier cream after each episode of incontinence as the resident still had multiple episodes of soft stool. The Note directed staff to reposition the resident with heels floating and pillows providing support. The Note documented the resident had been non-compliant with said measures and repeatedly rolled him/herself onto the back.

The Weekly Wound Observation Tool dated 6/28/17 documented an acquired area to the intergluteal cleft on 6/26/17 with that measured 15 millimeters (1.5 centimeters) x 7 millimeters (0.7 centimeters), and depth 2 millimeters (0.2 centimeters). The Tool documented the visible tissue had been pink epithelial moist tissue, without drainage.

Upon record review weekly wound assessments were completed to the intergluteal cleft area after the date 6/28/17 up to 7/19/17.

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The Wound Weekly Observation Tool dated 7/19/17 documented the intergluteal cleft measured 15 millimeters x 11 millimeters, with a depth of depth 2 millimeters. The Tool documented the visible tissue had been pink, and dry without drainage.

The Wound Weekly Observation Tool dated 7/5/17 documented an acquired area to the left heel on 6/29/17 that measured 75 millimeters x 70 millimeters with no depth. The Tool documented this had been the first observation. The area to the left heel had been identified by a Nurse Progress Note dated on 6/18/17, but the Nurse Progress Note lacked a complete assessment of the area.

The Wound Weekly Observation Tool dated 7/19/17 documented left heel measurements of 45 millimeters x 30 millimeters and no depth, with dry skin.

The Wound Clinic Progress Note dated 8/1/17 documented the coccyx wound currently presented as a Stage 3 pressure injury and the heel wound could have presented as a deep tissue injury, so it needed to be staged at a 3 or 4. The nature of the wound is pressure injury. Left Heel; small dark pink spots and weeping of serous fluid in several spots on the post left heel where a large, dry, black eschar (scab) was removed. After the eschar had been removed a 1 centimeter by 3 centimeter linear area of non blanchable dark pink red tissue surrounded by new epithelium remained. Coccyx wound measured 2 centimeters by 1.2 centimeters with a depth of 0.15 centimeters. The coccyx wound bed appeared clean, moist, roughly 30 percent granulation, 70 percent adherent slough with what

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appeared to be granulation buds noted within the slough in the wound bed.

The facility did not provide the survey team with an initial Care Plan for the resident.

The Care Plan with initiated date of 6/29/17 directed staff to float heels in bed, have the resident up in the wheelchair twice a day for two hours in the morning and evening, and to wear boots while in the wheelchair. The Care Plan also documented the resident required total assistance of two staff members for repositioning and turning in bed at least every two hours and as necessary.

During an observation on 8/01/17 at 7:45 a.m., the resident had been laying on the back in bed, with heel protectors on. However, the resident's heels were directly on the bed, and the Hoyer sling had been under the resident.

During an observation on 8/01/17 at 1:47 a.m., the resident had been on the back, with heel protectors on. However the heel protectors appeared worn and ineffective because the residents heels were directly on the mattress.

During an observation on 8/01/17 at 2:27 p.m., the residents left heel contained a large white and dark brown loose scab with bloody drainage.

During an interview on 8/01/17 at 2:59 p.m., Staff C and Staff D both certified nurses aides reported they were not sure when the heel protectors started being used.

During observation on 8/2/17 at 7:20 a.m., the resident had been positioned on his/her back,

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with heels touching the mattress.

During an interview on 8/2/17 at 9:12 a.m., Staff A, Licensed Practical Nurse (LPN) reported if a resident had a blister or boggy heel no skin sheet is started by facility staff. Staff A stated sheep skin had been started when she first noticed the spongy heel, and then later heel protectors were added. Staff A stated the resident had a standard facility mattress.

During an interview on 8/2/17 at 9:43 a.m. Staff F, Certified Nurses Aide (CNA.) reported the resident had a roho cushion in the wheelchair, but had not been sure when the facility started the heel protectors. Staff F reported the Hoyer sling should be out from under the resident when the resident is in the bed. Staff F stated staff should turn the resident every two hours while he/she is in bed.

During an interview on 8/2/17 at 9:50 a.m., Staff G CNA reported staff were to assure the resident was repositioned every two hours, their heels were floated off the bed, and heel protectors were applied when the resident was up in the wheelchair.

During an interview on 8/2/17 at 10:00 a.m. Staff E, Registered Nurse reported if a resident had a blister or spongy heel, staff initiate a skin sheet right away, and then notify the wound nurse, family, and doctor. Staff E could not remember when the heel protectors started.

During an interview on 8/3/17 at 8:30 a.m. Staff B, RN (facility wound nurse) reported she would expect staff to notify her of any skin changes; she would complete weekly measurements and also

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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 two weeks ago.

During an interview on 8/3/17 at 1:09 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 documented a request for 2 wedge cushions.

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F 323 SS=J	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and family interview, the facility failed to implement interventions to prevent a fall for 1 of 2 residents who experienced a fall that resulted in a major injury (Resident #19), failed to implement	F 323		

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interventions to prevent future falls for 1 of 6 residents with a history of falls (Resident #14).

The facility also failed to ensure the resident environment remained as free from accident hazards as possible for 3 of 12 residents sampled (Residents #6, #15, #16). Specifically, the facility failed to implement a system to ensure gaps in side rails were not large enough to create the risk for entrapment and serious injury which placed the residents in immediate jeopardy. The facility reported a census of 46 residents.

Findings include:

Review of the Food and Drug Administration's (FDA) Hospital Bed Safety Workgroup article, "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings," dated April 2003, indicated, in pertinent part,"...Use of bed rails should be based on patients' assessed medical needs and should be documented clearly and approved by the interdisciplinary team...Bed rail use for patient's mobility and/or transferring, for example, turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan...Inspect, evaluate, maintain, and upgrade equipment(beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards and appropriately match the equipment of patient needs, considering all relevant risk factors...If it is determined that bed rails are required...The mattress to bed rail interface should prevent an individual from falling between the mattress and bed. Maintenance and monitoring of the bed, mattress, and accessories such as

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patient/caregiver assist items...should be ongoing..."

According to the FDA's Guidance for Industry and FDA Staff article, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," issued 3/10/06, "For 20 years, FDA has received reports in which vulnerable patients have become entrapped in hospital beds while undergoing care and treatment in health care facilities. The term "entrapment" describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. FDA received approximately 691 entrapment reports over a period of 21 years from January 1, 1985 to January 1, 2006. In these reports, 413 people died, 120 were injured, and 158 were near-miss events with no serious injury as a result of intervention. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. Entrapments have occurred in a variety of patient care settings..."

1. The Quarterly Minimum Data Set (MDS- a federally mandated resident assessment tool) with an assessment reference date of 05/06/2017 revealed a BIMS (Brief Interview of Mental Status) of 15 which indicated minimal or no long and short term memory deficits. Resident # 6

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required extensive assistance from 1 staff for bed mobility, transfers, personal hygiene, and toilet use. The MDS documented occasional bowel incontinence and an indwelling urinary catheter to release urine from the bladder. Active diagnoses included diabetes mellitus, a seizure disorder, psychotic disorder, and legally blind.

The plan of care with a problem revision date of 01/03/2016 directed facility staff to use half rails on the resident's bed for safety, observe for injuries or entrapment, monitor behaviors every shift due to verbal aggression and psychosis, place a star on the name plate to identify for risk of falls, and monitor for seizures.

An undated facility document entitled "Side Rail Policy" listed the following guidelines:

1. All residents will be evaluated for the appropriateness for use of bed rails prior to initiation on admission.
2. The Rehab department will assess the need for bed rails for mobility.
3. Evaluations will include risk of entrapment.
4. Maintenance will follow guidelines for measuring rails.
5. Assure that the bed's dimensions are appropriate for the resident's size and weight.
6. The facility will incorporate the guidelines from regulating agencies in regards to Bed Safety.

The facility's Side Rail Rational Screen with an assessment date of 08/03/2017 indicated side rail would promote independence of movement for the resident. Resident # 7's poor visual acuity and decreased hearing complicated communication and understanding. A fracture to the right ankle and decline in overall function

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increased the risk of falls. The plan of care documented 1 staff person needed to assist with transfers and personal cares.

The Fall Risk Assessment completed on 03/31/2017 revealed a score of 16. A score of 10 or above indicated a high risk for falls.

During an interview on 07/31/2017 at 11:50 A.M., Resident # 6 sat in a chair at bedside. An observation of the upper 1/2 rails (in the up position) noted the middle opening in the rail exceeded the 4.75 inches allowed. The bed rails failed to have any padding in case of seizures.

An observation on 08/03/2017 at 12:00 P.M., found Resident #6 out to lunch. Both upper 1/2 rails remained in the up position. A ruler measurement of the middle part of the bed rail discovered the open area to be 7.5 inches horizontally by 7.75 inches vertically which is in excess of the 4.75 inches allowed. Both of the upper bed rails measured the same 7.5 by 7.75 inches for the opening.

2. An observation of an unoccupied bed in room 100 (bed 2), revealed 2 metal rails which exceeded the guidelines for bed rail openings. The middle bar opening measured 7.5 inches horizontally and 17.5 inches vertically.

3. According to the MDS dated 07/14/2017, resident #16 had a BIMS score of 13 which indicated the resident experienced intact long and short term memory deficits. Staff provided extensive assistance with bed mobility due to both upper and lower extremity impairments. Diagnoses included diabetes mellitus, a cerebral vascular accident, hemiplegia, a seizure

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disorder,Schizophrenia, and depression.

The plan of care with a revision date of 01/03/2016 directed staff to provide assistance with bed mobility and use side rails (1/2 rails) for safety. Staff should observe for entrapment.

A Side Rail Assessment completed on 08/03/2017 documented Resident # 15's lack of safety awareness, poor trunk control, and required frequent monitoring by staff. Recommendations included the resident's desire for bed rails and to promote independence.

During this assessment period the resident received antipsychotic medications 7 of 7 days.

Observations of bed 2 in room 306 on 03/2017 at 11:30 A.M., found the bed to be horizontal along the length of the room. The bed 1/2 rail towards the wall did not meet the 4.74 requirements for openings in a rail. Both rails were in the upright position. The middle opening measured 7.5 inches horizontally and 7.75 inches vertically. The bed rail toward the center of the room met standards.

The heating register ran the length of the room behind the bed and did not allow the bed to be placed flush against the wall. The bed's distance from the wall with the rail in the up position measured 6.75 inches. A bed placed against the wall with the heat register could become a fire risk.

4. The Annual MDS dated 05/26/2017 documented Resident # 16's difficulty with long and short term memory
and severely impaired decision-making abilities.

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Facility staff provide extensive assistance with all personal cares and bed mobility. Resident #16 displayed no upper or lower extremity limitations. Diagnoses included Non-Alzheimer's dementia, a seizure disorder, and a compulsive personality disorder.

The plan of care with a revision date of 01/01/2017 directed facility staff to assist with turning and repositioning in bed and provide seizure precautions.

The Side Rail Assessment of 08/03/2017 indicated Resident # 16 demonstrated alterations in safety awareness and needed to be monitored frequently at night. The facility removed the side rails.

The Side Rail Assessment of 05/28/2017 documented the altered, poor trunk control, medications which required safety precautions, and the need for frequent monitoring.

Observation of Bed # 1 in room 306 noted bilateral 1/2 rails in the up position. Both rails displayed a middle bar which failed to meet the 4.75 inch total for openings in a rail. The opening measured 7.5 inches horizontally and 4.75 inches vertically. Neither rail contained any padding for the diagnoses of seizures.

On 8/2/17, the facility abated the Immediate Jeopardy by removing the siderails which were out of compliance, educated staff and showed a policy for monitoring and assessing siderails for current and future residents. The scope and severity of the deficiency was lowered from a "J" to a "G" due to a fall with major injury detailed immediately below.

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5. The MDS (Minimum Data Set) assessment tool, dated 6/30/17, listed diagnoses for Resident #19 included muscle weakness, heart failure, and diabetes. The MDS stated the resident required extensive assistance of 1 staff for dressing, extensive assistance of 2 staff for bed mobility, depended totally on 1 staff for personal hygiene and bathing, and depended totally on 2 staff for transfers and toilet use. The MDS stated the resident did not walk during the review period and listed the resident's BIMS (Brief Interview for Mental Status) score as 15 out of 15, indicating intact cognition.

A fall incident report, dated 7/9/17, documented the nurse received a phone call at 10:51 p.m. from the resident's roommate who stated the resident needed help. The nurse sent a CNA (Certified Nursing Assistant) to the room and the CNA assisted the resident to get his/her feet back into the bed. At 10:57 p.m., the nurse received a second phone call from the resident's roommate who stated the resident needed help. The report stated the nurse responded immediately and the resident was on the floor beside the bed with his/her left leg buckled under him/her. The resident was crying out in pain and stated "I felt my hip pop when I rolled out of bed, I was just trying to adjust myself when my legs fell out of bed and then I rolled out onto the floor." The report stated the facility sent the resident to the hospital.

A care plan entry, revised 11/3/16, documented the resident preferred all 4 bed rails up.

A care plan entry, revised 4/13/16, documented the resident was at high risk for falls and the

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resident would be free of serious injury through the review date. The care plan included the following interventions:

a. Be sure the resident's call light is within reach and encourage the resident to use it.
b. Front wheelie bars to wheelchair to prevent it from tipping forward
c. Physical therapy to evaluate and treat as ordered and as needed

The care plan lacked any interventions to prevent the resident from slipping out of bed.

The facility schedule for the 10:00 p.m. - 6:00 a.m. shift on 7/9/17 listed 1 nurse and 2 CNAs for the entire shift and 1 additional CNA working from 2:00 a.m. onward. The schedule listed another CNA with her name crossed out.

The facility policy on side rails, dated 6/28/17, stated full top and bottom side rails were strictly prohibited.

A 7/10/17 hospital report revealed the resident sustained a fracture of the left femur (thigh bone) treated with an intramedullary rod (a rod used to treat fractures of long bones of the body).

During an interview on 7/13/17 at 5:05 a.m., Staff N CNA stated he worked at the facility on 7/9/17 from 6:00 p.m.-6:00 a.m. He stated aside from a CNA working in the unit, he was the only CNA in the building as well as the nurse. He stated he was helping another resident when Resident #19's call light was on. Resident #19's roommate called the facility on the phone for help and Staff O asked him to check on him/her. When he entered the room, both of the resident's legs were

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hanging out of the bed. Staff N placed the resident's legs back in bed. The resident requested body pillows on each side. Staff N then helped another resident and Staff O found the resident when he/she fell which Staff O thought was around 11:00 p.m. He stated the resident did not fall or have his/her legs out of the bed when all 4 side rails were on the bed. He stated the resident requested all 4 side rails and it was in the care plan and the resident was upset he/she did not have the lower side rails anymore.

During an interview on 7/13/17 at 7:01 a.m., Staff O RN(Registered Nurse) stated she worked 6:00 p.m.-6:00 a.m. on 7/9/17. She stated on 7/9/17, she was sending another resident to the emergency room when she received a phone call at 10:51 p.m. from Resident #19's roommate who stated Resident #19 needed help. Staff O sent Staff N CNA to the resident's room to help him/her. After Staff N returned, he told Staff O he found the resident in bed with his/her legs coming out of the bed and he put his/her legs back and repositioned him/her. At 10:57 p.m., Staff O received another phone call from the roommate who stated the resident needed help. Staff O stated she heard Resident #19 screaming but couldn't remember if this was on the phone or after she arrived in the resident's room. She stated she went to the resident's room and found the resident on the floor on the buttocks with his/her legs buckled under him/her. The resident told her he/she was trying to reposition himself/herself and rolled out of bed.. The resident stated his/her legs were out and the body followed. Staff O then called an ambulance. She stated on this shift, the third CNA did not show up or call. Staff O stated on another instance, the resident's legs were hanging out of

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bed but there was no fall.

During an interview on 7/12/17 at 10:55 a.m., the resident's roommate stated Resident #19 fell sometime between 10:30-10:45 p.m. He/she stated Resident #19 told him/her he/she was falling out of bed and asked him/her to call for help. The roommate pulled the call light but no one came to assist. They both yelled for help and Staff N CNA arrived and helped place the resident's feet back in bed. Not long after that, the resident stated he/she was falling out of bed again. The resident pulled the call light again but no one came to assist. The roommate then called the facility on his/her cell phone and stated someone answered and told him/her they were busy with another emergency and he/she would have to wait. The roommate stated the resident then fell out of bed and he/she heard a "pop" sound and the resident started screaming. The roommate called the facility again on his/her cell phone and he/she stated staff told him/her they were busy and to stop calling. He/she stated he/she then held the phone up so they could hear the resident screaming and stated they hung up on him/her. He/she stated no one came for almost 10 minutes after the resident fell. The roommate stated he/she could not help the resident and couldn't get any of the staff to help either. He/she stated he/she thought the facility removed the resident's side rails sometime last week and the resident started to slip his/her legs out of bed a couple times before this fall.

During an interview on 7/12/17 at 11:20 a.m., the MDS Coordinator stated she removed 4 side rails from the care plan due to "company policy. She stated the owners directed that residents could not have all 4 side rails because it was a restraint.

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She stated maintenance removed the lower 2 side rails from every resident who had them.

During an interview on 7/13/17 at 8:29 a.m., the ADON (Assistant Director of Nursing) stated she was the manager on call for the night of 7/9/17. She stated she received a call sometime after 10:00 p.m. stating that a CNA did not show up.

During an interview on 8/8/17 at 11:04 a.m., the resident's daughter stated the resident's roommate told her 2-3 days prior to the fall the resident had been falling out of bed.

During an interview on 8/8/17 at 11:20 a.m., Staff P CNA stated at one time the resident had 4 side rails and was very angry when the facility removed 2 of the side rails. She stated after he/she had only 2 side rails, staff would walk by his/her room and see his/her feet dangling out of bed and would need to go in and help him/her put them back.

During an interview on 8/9/17 at 9:16 a.m., the Maintenance Supervisor stated the Administrator instructed him to remove the 2 bottom side rails from some beds and stated it was a "state mandated decision".

During an interview on 8/8/17 at 11:36 a.m., the DON (Director of Nursing) stated the facility removed the resident's side rails and staff put a pillow under the resident's sheet to keep him/her from rolling out of bed.

6. The MDS assessment tool, dated 5/26/17, listed diagnoses for Resident #14 included muscle weakness, schizophrenia, and coronary artery disease. The MDS stated the resident

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required supervision assistance with eating, limited assistance of 1 staff for personal hygiene, and extensive assistance of 1 staff for bed mobility, transfers, dressing, toilet use, and bathing. The MDS revealed the resident did not walk during the review period and was not steady and only able to stabilize with staff assistance when moving from seated to standing position, moving on and off the toilet, and transferring between bed and chair or wheelchair. The MDS stated the resident had 2 falls resulting in no injury since the last assessment and listed the resident's BIMS score as 8 out of 15, indicating moderately impaired cognition.

During an observation on 8/7/17 at 3:00 p.m., the resident laid in bed. No floor mat was present in front of the bed. The call light was not in reach of the resident.

During an observation on 8/8/17 at 8:06 a.m., the resident's door was almost completely closed (open approximately 1 inch). The resident lay in bed and no floor mat was present in front of the bed. A sign on the outside of the door directed the resident to ask the staff for assistance. With the door closed, the sign could not be seen by the resident.

During an observation on 8/8/17, the resident's door was completely closed.

During an observation on 8/8/17 at 11:42 a.m., the resident wheeled himself/herself back from lunch. As he/she was entering the room, Staff H CNA told the resident to pull the call light if he/she needed anything. Staff H did not offer to assist the resident to the toilet or assist the resident with anything in his/her room. The resident then

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wheeled himself/herself into his/her room and closed the door until it was open about 1 inch. The resident stood up by himself/herself from the wheelchair, turned around, and sat on the bed.

Progress notes, dated 11/12/16 5:53 a.m. revealed a staff member found the resident on the floor and the resident stated he/she fell after trying to turn around in the bathroom. The resident complained of leg, knee, and side hip pain.

A 12/6/16 10:40 a.m. incident report revealed the staff found the resident lying on the floor of the bathroom. The resident stated he/she got his/her feet tangled and fell on the buttocks. The report revealed the resident sustained no injuries and listed the interventions of encouraging the resident to ask for assistance and the installation of grab bars in the bathroom.

A 12/14/16 3:00 a.m. incident report documented the resident sat on the edge of the bed and slid onto the floor and sustained no injury.

A 12/14/16 3:00 p.m. incident report stated the resident transferred themselves from the bed to the wheelchair and the wheelchair rolled and he/she slid out. The resident sustained a skin tear and the intervention listed to prevent a recurrence was add an anti-roll back device to the wheelchair and change the resident's transfers to require an assist of 1 staff for transfers. The report documented the resident went to the emergency room.

Progress notes, dated 12/14/16 5:05 p.m., revealed a staff member found the resident on the floor; the resident had hit his/her head against

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the bed. The resident complained of pain from his/her neck down to the back so the facility sent him/her to the emergency room.

Progress notes, dated 12/15/16 at 2:09 a.m., documented the resident returned from the hospital at 7:00 p.m. with no new orders.

A 12/14/16 3:43 p.m. hospital report documented the resident sustained a superficial (not deep) skin avulsion (tearing) of the right great toe.

A 5/4/17 hospital report revealed the resident fell from the toilet while sleeping and sustained hip contusions (bruises).

A 5/5/17 incident report documented the resident took themselves to the bathroom and fell off the toilet onto the floor. The incident report documented Resident # 14 complained of pain in the right shoulder.

A 5/17/17 physician's report revealed the resident had new and old compression fractures and osteoporosis. The physician ordered an LSO (lumbar sacral orthosis) brace (a brace used to support the spine) and stated the resident needed a DEXA scan (a scan measuring bone density) and treatment for osteoporosis. The report described the resident as at substantial risk for further compression fractures and documented the resident should return for a follow up appointment in 6 weeks.

The facility records lacked documentation of the completion of a DEXA scan or the initiation of osteoporosis treatment. The facility also had no documentation to indicate the resident received an LSO brace or attended a follow up

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appointment in 6 weeks.

A 5/22/17 incident report revealed staff found the resident on the floor by the bathroom door. The resident stated he/she came out of the bathroom and started shaking. The resident's roommate came over to help but the resident shook so much he/she let go and the resident sat on the floor. The report documented the resident sustained no injuries.

A 5/23/17 radiology report indicated the resident had mild compression deformities, potentially new since 2/20/16, but duration unknown. The radiology reported also listed chronic compression fractures of variable severity.

Progress notes, dated 5/24/17 at 1:35 a.m. (late entry), revealed staff found the resident on the floor lying on the right side. The resident complained of pain in the right hip, back and arm; the facility sent the resident to the emergency room.

A hospital report, dated 5/24/17, revealed the resident experienced a fall that resulted in a right hip bruise and a mild closed head injury.

A 5/25/17 fall incident report documented the resident attempted to transfer themselves out of bed without assistance and slid to the floor. The incident report revealed the resident sustained an abrasion to the left toe. The report documented the facility gave the resident a high/low bed, re-instructed the resident to use the call light, and placed a mat on the floor in front of the bed.

A 5/25/17 physician's order documented an order for Occupational Therapy and Physical Therapy

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to evaluate and treat.

A 5/25/17 Therapy Screening Form documented the resident had difficulty performing activities of daily life, reduced upper/lower extremity functioning or muscle weakness, difficulty with mobility (transfers) and was at risk for falls. The screening recommended both Occupational Therapy and Physical Therapy for the resident.

The facility lacked documentation the resident began Occupational Therapy or Physical Therapy.

A 6/4/17 incident report showed a nurse found the resident lying on the floor in front of the wheelchair. The report documented the resident stated he/she went to the bathroom and didn't quite make it back to the the chair. The report revealed the resident sustained no injuries and documented the nurse reminded the resident to utilize the call light and leave the door open.

A 6/19/17 incident report documented staff found the resident lying on the right side on the floor in front of the wheelchair. The report revealed the resident sustained no injuries.

A 7/4/17 incident report documented the resident tired to urinate in the trash, lost his/her balance and fell on a mat near the bed. The resident stated he/she tried to go to the bathroom and lost his/her balance.

The care plan included the following dated entries:

4/28/17 The resident is able to use the toilet himself/herself.

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4/28/17 The resident required supervision to transfer.
7/17/17 The resident required moderate to maximum assist of 1 staff with transfers.
6/15/17 Attempt to toilet before/after meals.
7/11/17 Be sure the resident's call light is within reach.
7/11/17 Place a floor mat beside the bed.

A 8/3/17 Fall Risk Assessment stated the resident was at high risk for falls.

During an interview on 8/7/17 at 3 :30 p.m., Staff I CMA (Certified Medication Aide) stated the resident did not require assistance with transfers.

During an interview on 8/8/17 at 8:15 a.m., Staff J CMA stated the resident went to the bathroom independently.

During an interview on 8/8/17 the Director of Nursing stated she never saw the resident wear a brace.

During an interview on 8/8/17 at 9:29 a.m., Staff H CNA stated the resident sometimes needed help with transfers but sometimes transferred to his/her chair before she could help him/her.

During an interview on 8/8/17 at 11:45 a.m., the ADON (Assistant Director of Nursing) stated the facility didn't have "much luck" obtaining a brace from orthopedics and stated Hospice canceled the 6 week follow-up with the physician. She stated the local clinic didn't carry out DEXA scans and she didn't realize this until the resident arrived at the clinic. She stated the resident had an x-ray in lieu of the DEXA scan.

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F 323	Continued From page 51 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 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. 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 room and reported the facility was going to work on changing the care plans in the future.	F 323		
F 363 SS=E	MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED CFR(s): 483.60(c)(1)-(7) (c) Menus and nutritional adequacy. Menus must- (c)(1) Meet the nutritional 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 religious, cultural and ethnic needs of the resident population, as well as input received	F 363		

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from residents and resident groups;

(c)(5) Be updated periodically;

(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and

(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility policy review, the facility failed to provide those on regular diets (47 residents) with 4 ounces of potato wedges to ensure the same nutritional equivalents as 4 ounces of mashed potatoes for those on pureed diets. The facility reported a census of 49 residents.

Findings include:

During an observation of the kitchen and the pureed process on 08/01/2017 at 10:30 A.M., Staff L (dietary cook) stated the pureed diets would be getting 4 ounces of mashed potatoes instead of the potato wedges.

Observations of the menu at that time, revealed the regular diets would receive 3 potato wedges for 1 portion of potatoes. During observations of the noon meal service at 11:15 A.M. on 08/02/2017, Staff H placed 3 potato wedges of potato using tongs, (not a 4 ounce spoodle) on each plate for the regular diets.

When finished at 12:15 P.M., the Dietary Manager placed the 3 potato wedges on a scale.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 363	Continued From page 53 3 potato wedges weighed 1.5 ounces. The use of a 4 ounce spoodle for the potato wedges would provide a more consistent nutritional equivalent. The Daily Spreadsheet for week 2 with the varied diets outlined, 4 ounces of mashed potatoes for he pureed diets and only 3 potato wedges for regular diets.	F 363		
F 465 SS=F	SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON CFR(s): 483.90(i)(5) (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain a clean and functional environment. The facility reported a census of 46 residents. Findings include: 1. During the environmental tour on 8/2/17 at 12:04 p.m., the following concerns were revealed: a. The door knob on the door to the service entrance was not secured tightly to the door and was loose and bent.	F 465		

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F 465	Continued From page 54 b. The tile in the shower room in the 600 Hall had a black mold-like substance in between each tile in the grout. During an observation on 8/3/17 at 9:00 a.m., the shower room in the 100 Hall had a black mold-like substance on the tiles and the walls of the shower room. The undated facility housekeeping daily cleaning schedule directed staff to spray the shower floors and walls and utilize a long-handled brush if necessary. During an interview on 8/3/17 at 11:30 a.m., the Administrator provided the survey team with the facility cleaning schedule and stated cleaning the showers was a regular part of the housekeeping duties.	F 465		
F 497 SS=D	NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE CFR(s): 483.35(d)(7) (d)(7) Regular In-Service Education The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review and facility interview, the facility failed to assure that 4 of 10 Certified Nursing Assistants reviewed attended 12 mandatory inservices on a yearly basis. The facility reported a census of 46 residents.	F 497		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	08/14/2017

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F 497	Continued From page 55	F 497		

Findings include:

On a yearly basis, all employed Certified Nursing Assistants must attend all 12 of the mandatory inservices provided by the facility.

Staff K attended only 3 of the 12 mandatory inservices in 2016.

Staff C attended 6 of the 12 mandatory inservices in 2016.

Staff Q attended only 2 of the 12 mandatory disservices in 2016.

Staff J attended 10 out of 12 mandatory inservices in 2016.