		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 02/13/2018 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT CON	E SURVEY
i are	hina an ta	165585	B. WING		1	C 16/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	27.87	1990 A. 1999
PEARL	ALLEY REHABILITAT	ION AND HEALTHCARE CENTE	R	2002 CEDAR STREET MUSCATINE, IA 52761		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	F 000			
./	Correction Date	1-17-18				
OMPH		nation relates to the pplaint #73329-C and 73346-C 1/16/18.				
	Both complaints we	re substantiated.				
F 713	483, Subpart B-C. Physician for Emerg	al Regulations (42 CFR) Part gency Care Available 24 hrs	F 713			-
SS=L	§483.30(d) Availabil emergency care The facility must pro- provision of physicia case of emergency. This REQUIREMEN by: The following inforr of #73329 and #733 Based on record re- facility failed to prov services 24 hours a did not have an agr provide services in a physician/medical d director informed th terminating services office failed to alert medical director. The residents used the a primary physician. The available physician and emergency or for case	ovide or arrange for the an services 24 hours a day, in NT is not met as evidenced mation relates to investigation		TITLE		(X6) DATE

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.

02/01/2018

	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165585	(X2) MULTIPLE A. BUILDING B. WING		3) DATE SURVEY COMPLETED C 01/16/2018
	PROVIDER OR SUPPLIER	TION AND HEALTHCARE CENTE	R 200	REET ADDRESS, CITY, STATE, ZIP CODE 22 CEDAR STREET JSCATINE, IA 52761	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 713	of residents at an ir Specifically, Reside respiratory infection distress, the facility contact for consulta interventions, result to the emergency re record showed the he was not on call a needed to fax anoth the Director of Nurs not inform the charge	nmediate jeopardy. ant #1 with a known history of a developed respiratory did not have a physician to a developed respiratory did not have a physician to a physician and new orders for ting in the resident being sent bom. Resident #5's clinical on-call physician responded anymore and the facility her physician. Interview with sing (DON) revealed she did ge nurses there was no available. The facility reported	F 713		
	Findings include:				
	Vice President of P local hospital conta Executive Director (implementation of a section 10.2 of the detailed 1/3/18 as the relationship at the fail if he/she wanted the 12/5/17, the VP aga wanted the VP to co at 4:01 p.m., the CE would let the facility a.m., the VP contact him/her that they we and faxes from the				
	Corporate Regional reported the Admin 1/5/18. The Admin	0/18 at 4:58 p.m. the I Vice President (RVP) istrator called him/her on istrator reported he she n from the VP that the Medical			

		AND HUMAN SERVICES					FORM	: 02/13/2018 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONST	RUCTION		CON	E SURVEY
23.95		165585	B. WING					C 16/2018
NAME OF	PROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP	CODE		
PEARL	ALLEY REHABILITAT	TION AND HEALTHCARE CENTE	ER 2002 CEDAR STREET MUSCATINE, IA 52761					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO EACH CORRECTIVE ACTIO OSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 713	Director's contract v called the CED and Director was still ac call the Medical Dire Medical Director wh contract was termin physician to find phy weekend. The RVF who agreed to cove called the on-call ph he/she would contin physician declined. the CED's last day of called the new CED them the facility did for the residents on Owner said they wo called the state to in The RVP called the the state was conta that there was no w inform the state. An interview on 1/10 of Nurses (DON) the to provide orders the An interview on 1/9/ on-call physician rep residents at the faci 1/5/18 and ended ca An interview on 1/9/ (Charge Nurse) rep something was wrow and the on-call physic Staff A reported all of Medical Director as	was terminated. The RVP the CED reported the Medical tive. The CED told the RVP to ector. The RVP called the no informed the RVP that the nated. The RVP called a sysician coverage over the P found an on-call physician er through 1/8/18. The RVP hysician on 1/8/18 to ask if nue to cover. The on-call The RVP reported 1/17/18 is covering Iowa. The RVP and the Owner to inform not have physician coverage 1/9/18. The new CED and build take care of it. The RVP form them of the situation. Owner to inform him/her that cted. The RVP told the Owner ay he/she could ethically not	F 7	13				

Facility ID: IA0930

If continuation sheet Page 3 of 9

		AND HUMAN SERVICES				FORMA	02/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
		165585	B. WING			01/1	; 6/2018
NAME OF I	PROVIDER OR SUPPLIER	-	<u> </u>	STREET ADDRESS	S, CITY, STATE, ZIP CODE		
PEARL	ALLEY REHABILITA	TION AND HEALTHCARE CENTE	R	2002 CEDAR STE MUSCATINE, IA		10	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD EFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 713	a resident required reported he/she pla was an emergency An interview on 1/9 reported he/she fo Administrator that t coverage. The DO Resident #1 with up today. An interview on 1/9 Administrator repor contract with for the not have a signed of 2. According to the 1/9/18 Resident #1 infarct, acute upper diplegic cerebral pa The Minimum Data 10/4/17 revealed R assistance with dre personal hygiene a	physician services. Staff A inned to call the DON if there /18 at 4:53 a.m. the DON und out this morning from the he facility had no physician N reported the staff sent out oper respiratory issues earlier /18 at 4:40 p.m., the ted he was working on the e new Medical Director and did contract yet. Admission Record dated had diagnoses of cerebral respiratory infection, spastic alsy and dysphagia. Set (MDS) assessment dated esident #1 required total staff ssing, eating, toilet use	F 7	13			
	assistance of one s bed, transfer with a respond due to con stroke, difficulty che pneumonia.	staff to turn and reposition in sit to stand lift, allow time to nmunication deficit from ewing and history of aspiration					
	revealed Resident room by ambulance on room air. Resid cough and wheezin	s dated 1/9/17 at 12:41 p.m. #1 sent to local emergency e due to oxygen level 78 -83% ent #1 had a non-productive ig in all lung fields. Resident	11	Equility ID: 100020	lf anntiau	ation share	t Page 4 of 0
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: PKGY	11	Facility ID: IA0930	If continu	ation shee	t Page 4 of 9

CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 093-0391 STATEMENT OF DEFINITION (P) PROVIDENSING IDENTIFICATION NUMBER: (P2) MULTIPLE CONSTRUCTION A BUILDING (P2) DUTE SUPER- BUILDING			AND HUMAN SERVICES				FORM	02/13/2018 APPROVED
165585 B. WIND 01/16/2018 NAME OF PROVIDER OR SUPPLIER BITREET ADDRESS, CITY, STATE, ZIP CODE 2002 CEDAR STREET MUSCATINE, IA 52751 CODE CEDAR STREET MUSCATINE, IA 52751 CODE CROSHEETS PLAN OF CORRECTION (EACH CORRECTIVE AND SHOULD BE CROSHEETS PLAN OF CORE SHOULD AND THE AND FOOTE	STATEMENT	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	a contraction of the second second			(X3) DAT COM	E SURVEY PLETED
PEARL VALLEY REHABILITATION AND HEALTHCARE CENTER 2002 CEDAR STREET MUSCATINE, IA 52761 0010 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EQCH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR IS DEMTIFYING INFORMATION) 0 PACING PREFIX TAG PREFIX (EQCH DERICENCY OR IS DEMTIFYING INFORMATION) 0 PACING PREFIX TAG PREFIX (EQCH DERICENCY OR IS DEMTIFYING INFORMATION) 0 PACING PREFIX TAG PREFIX (EQCH DERICENCY OR IS DEMTIFYING INFORMATION) 0 PACING PREFIX TAG PREFIX (EQCH DERICENCY PREFIX TAG PREFIX (EQCH DERICENCY PREFIX (EQCH DERICENCY OR IS DEMTIFYING INFORMATION) 0 PACING PREFIX TAG PREFIX (EQCH DERICENCY PREFIX TAG PREFIX (EQCH DERICENCY PREFIX (EQCH DERICENCY PREFIX (EQ	i di		165585	B. WING	÷			
Přěčik TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISCIDENTIPINIS INFORMATION) Přěřik TAG (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION F 713 Continued From page 4 #1 had a temperature of 97.8 degrees Fahrenheit, pulse of 88 and blood pressure of 133/84. F 713 F 713 The Nursing Communication Form dated 1/9/18 revealed Staff B emailed the physician. The nurses comments revealed Resident #1 had cold symptoms the last 3 days, no temperature, vital signs within normal limits and bad cough. Staff B reported Resident #1 had chest congestion, difficulty breathing and low oxygen saturation at 83%. Staff B reported he/she did not get an order to send Resident #1 ad chest congestion, difficulty breathing and low oxygen saturation at 83%. Staff B reported normally she would obtain an order and reported there was a note at the nurses station directing the staff to contact the on-call physician. F 713 The facility fax Activity Report revealed no 11/9/17 at 1:12 p.m. a fax was attempted. However, the fax failed to send as it was sent to the on-call physician on 11/11/18 at 9:02 a.m. Staff C (Medical Records) reported he/she faxed th physician on 11/9/18. An interview on 11/11/18 at 9:02 a.m. Staff C (Medical Records) reported he/she pox to the on-call physician response to any faxes on 19/18. An interview on 11/11/18 at 9:02 a.m. Staff C (Medical Records) reported he/she spox to Staff B who reported he/she faxed the doctor the request for rough syrup, Staff C reported he/she looked through all the faxes for 1/9/18. There was no physician response to any faxes on 19/18.			ION AND HEALTHCARE CENTE	R	200	02 CEDAR STREET	DE	
 #1 had a temperature of 97.8 degrees Fahrenheit, puise of 88 and blood pressure of 133/84. The Nursing Communication Form dated 1/9/18 revealed Staff B emailed the physician. The nurses comments revealed Resident #1 had cold symptoms the last 3 days, no temperature, vital signs within normal limits and bad cough. Staff B requested an order for cough syrup as needed. An interview on 1/10/18 at 9:44 a.m. Staff B reported Resident #1 had chest congestion, difficulty breathing and low oxygen saturation at 83%. Staff B reported horshe did not get an order to send Resident #1 out [on 1/9/18]. Staff B was more worried about Resident #1s difficulty breathing. Staff B reported horshe did not get an order to send Resident #1 out [on 1/9/18]. Staff B was more worried about Resident #1s difficulty breathing. Staff B reported hershe would obtain an order and reported there was a note at the nurses station directing the staff to contact the on-call physician. The facility fax Activity Report revealed on 1/9/17 at 1:12 p.m. a fax was attempted. However, the fax failed to send as it was sent to the on-call physician or 1/9/18. An interview on 1/11/18 at 9:02 a.m. Staff C (Medical Records) reported he/she spoke to Stafff B who reported he/she spoke to Stafff B who reported he/she for 1/9/18. There was no physician response to any faxes on 1/9/18. 	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	HOULD BE	COMPLETION
An interview on 1/10/18 at 3:20 p.m. the DON	F 713	 #1 had a temperatu Fahrenheit, pulse of 133/84. The Nursing Comm revealed Staff B em nurses comments re symptoms the last 3 signs within normal requested an order An interview on 1/10 reported Resident # difficulty breathing a 83%. Staff B report to send Resident #1 more worried about breathing. Staff B re obtain an order and the nurses station d on-call physician. St the on-call physician The facility fax Activ at 1:12 p.m. a fax wa fax failed to send as physician's cell phor revealed no other fa physician on 1/9/18. An interview on 1/11 (Medical Records) re B who reported he/s request for cough sy looked through all the was no physician results. 	re of 97.8 degrees f 88 and blood pressure of unication Form dated 1/9/18 ailed the physician. The evealed Resident #1 had cold 8 days, no temperature, vital limits and bad cough. Staff B for cough syrup as needed. 0/18 at 9:44 a.m. Staff B 1 had chest congestion, and low oxygen saturation at ed he/she did not get an order out [on 1/9/18]. Staff B was Resident #1's difficulty eported normally she would reported there was a note at irecting the staff to contact the aff B reported he/she faxed n. ity Report revealed on 1/9/17 as attempted. However, the it was sent to the on-call he number. The report xes sent to the on-call /18 at 9:02 a.m. Staff C eported he/she spoke to Staff the faxed the doctor the rrup. Staff C reported he/she faxes for 1/9/18. There	F	713			
		An interview on 1/10)/18 at 3:20 p.m. the DON					-

Facility ID: IA0930

If continuation sheet Page 5 of 9

		AND HUMAN SERVICES				FORM	02/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		165585	B. WING _				C 16/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
PEARL V	ALLEY REHABILITAT	TION AND HEALTHCARE CENTE	R	2002 CEDAR STREET MUSCATINE, IA 52761			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD TO THE APPROPE	BE	(X5) COMPLETION DATE
F 713	reported the Admin him/her the morning physician coverage not inform the charge physician coverage same time she hea ambulance was at 1 #1. Staff B told the because Resident # 2. According to the 1/11/18 Resident # atherosclerotic hea heart disease, stroke mbolism and cong The MDS assessm Resident #5 require of daily living. The Prothrombin Ti Normalized Ration Resident #5 had ar considered 0.8 - 1.2 responded to the fa p.m. The physiciar anymore and need The staff faxed the Director on 1/11/17 dosage of 2.5 millig 2 mg every Tuesda Friday, Saturday ar any change in dosa PT/INR. The Nursing Comm revealed the new M #5 and wrote an or	istrator and RVP informed g of 1/9/18 that there was no . The DON reported she did ge nurses there was no . The DON reported at the rd the ambulance sirens. The the facility to pick up Resident DON he/she called 911 #1 was in respiratory distress. Admission Record dated 5 had diagnoses of rt disease, chronic ischemic ke, history of pulmonary gestive heart failure. ent dated 12/6/17 revealed ed supervision for all activities ime and International (PT/INR) dated 1/1/8 revealed n INR of 1.2 (a normal range 2). The on-call physician exed results on 1/8/18 at 4:49 n noted he/she not on call to fax to another physician. results to the new Medical with the current Coumadin grams (mg) every Monday and by, Wednesday, Thursday, nd Sunday. The staff asked if age and if any recheck of	F 71				
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: PKGY	11	Facility ID: IA0930	If continu	ation she	et Page 6 of 9

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1	S. C. M. Market B. S.		0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CON	E SURVEY IPLETED C
1		165585	B. WING			16/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
PEARL	ALLEY REHABILITAT	TION AND HEALTHCARE CENTE	R I	2002 CEDAR STREET MUSCATINE, IA 52761		na string
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 713	every Monday Wed every Tuesday, Thu An interview on 1/17 reported he/she wa results returned from note that he/she wa send to another phy E took the fax to the concerned with no p was not returned to report the PT/INR re another doctor and taking care of it. An interview on 1/17 reported he/she too fax machine and sa noted "no longer on physician". Staff E who reported he/she weekend. Staff E th inform her there wa residents. Later the they could fax the o reported she left the An interview on 1/17 reported he/she did INR results until yes showed him/her. Th not say anything to An interview on 1/16	nesday and Friday and 2 mg insday, Saturday and Sunday. 1/18 at 11:38 a.m. Staff D s working when the PT/INR m the on-call physician with a as no longer on-call and to visician. Staff D reported Staff e DON. Staff E was obysician coverage. The fax Staff D. Staff D passed on in eturned with a note to fax to Staff E and the DON were 1/18 at 12:00 p.m. Staff E k the PT/INR results off the w that the on-call physician call contact another called the on-call physician e was only on call over the nen called the Administrator to s no doctor covering the e Administrator told Staff E n-call physician. Staff E afax with Staff D. 1/18 at 12:14 p.m. the DON not know anything about the sterday when the Surveyor he DON reported Staff E did him/her about it. 6/18 at 1:18 p.m. the DON	F 713			
	reported an expecta physician with lab re faxed and awaiting DON reported it too for a response. The	ation of the staff to notify the esults, document the lab was response from physician. The k from Monday until Saturday e DON reported the staff did			16	
FURM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: PKGY1	Fac	cility ID: IA0930	If continuation she	et Page 7 of 9

		AND HUMAN SERVICES			FORM	02/13/2018 APPROVED 0938-0391
STATEMENT OF D AND PLAN OF CO	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		165585	B. WING			C 16/2018
	IDER OR SUPPLIER	TION AND HEALTHCARE CENTE	R	STREET ADDRESS, CITY, STATE 2002 CEDAR STREET MUSCATINE, IA 52761	, ZIP CODE	1.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
resi F 947 SS=D F 947 SS=D S48 aide In-s S48 con be i S48 con be i	interview on 1/9, ninistrator report tract for new Me nediately. a facility abated f sician signed th eement on 1/9/1 actor. The contra- es which include rdinate medical to provide clinic dent care. a facility alerted in tact the physicia ase findings lowe quired In-Service R(s): 483.95(g)(3.95(g) Require es. service training r 3.95(g)(1) Be si tinuing compete no less than 12 (3.95(g)(2) Inclu- ning and resider (3.95(g)(3) Addr ermined in nurse	s faxed again on 1/11/18. /18 at 5:45 p.m. the ted the facility had a signed edical Director effective the IJ on 1/9/18 when a e Medical Director Service 18 to serve as the medical act included medical director ed: being responsible to care to residents at the facility cal oversight regarding nursing staff on 1/9/18 to an/medical director if needed. ered the IJ from an "L" to an E. e Training for Nurse Aides 1)-(4) ed in-service training for nurse must- ufficient to ensure the ence of nurse aides, but must	F 713			
det	ermined by the f		11 5	acility ID: IA0930	If continuation she	et Page & of 0

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/13/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY IPLETED
		165585	B. WING				C 16/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL	ALLEY REHABILITAT	ION AND HEALTHCARE CENTER	R		002 CEDAR STREET NUSCATINE, IA 52761		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 947	 §483.95(g)(4) For n to individuals with c address the care of This REQUIREMEN by: Based on record refacility failed to ensuin-service training for The facility reported Findings include: 1. The facility hired position of Nurse Airecords from 9/20/1 had zero in-service 2. The facility hired position of Nurse Airecords from 8/28/1 had zero in-service 3. The facility hired position of Nurse Airecords from 5/3/17 had zero in-service how Administrator reported for Nover the prior Administrator reported she started 12/18/18 conducted Administrator added 	urse aides providing services ognitive impairments, also the cognitively impaired. AT is not met as evidenced eview and interviews, the ure staff attended the required or 3 of 4 nurse aides reviewed. I a census of 55 residents. Staff F on 9/20/17 for the de. Review of the in-service 7 to 12/31/17 revealed Staff F hours. Staff G on 8/28/17 for the de. Review of the in-service 7 to 12/31/17 revealed Staff G hours. Staff H on 5/3/17 for the de. Review of the in-service to 12/31/17 revealed Staff H urs. on 1/16/18 at 1:00 p.m., the ted the in-service attendance e located for September and Administrator reported the nber 2017 was canceled by tor. The Administrator d in her current position on	FS	947			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: PKGY11 Facility ID: IA0930

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY		
		165585	B. WING		С			
	PROVIDER OR SUPPLIER					16/2018		
		TION AND HEALTHCARE CENTE	ER STREET ADDRESS, CITY, STATE, ZIP CODE 2002 CEDAR STREET MUSCATINE, IA 52761					
(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 ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 000	INITIAL COMMEN	TS	F 000	1				
	Correction Date							
		mation relates to the nplaint #73329-C and 73346-C o 1/16/18.						
	Both complaints we	ere substantiated.						
F 713	483, Subpart B-C.	al Regulations (42 CFR) Part	F 713					
	CFR(s): 483.30(d)							
	emergency care	ility of physicians for ovide or arrange for the						
	provision of physici case of emergency	an services 24 hours a day, in						
	by: The following infor	NT is not met as evidenced mation relates to investigation						
	of #73329 and #73							
	facility failed to prov services 24 hours a did not have an agr	view and interviews, the vide or arrange physician a day. In addition, the facility eement with a physician to the absence of the attending						
	physician/medical of director informed th terminating service	director. The prior medical ne facility he would be s and the facility's corporate the facility they were without a						
	medical director. The residents used the primary physician.	the facility reported all of the 55 medical director as their The failure to obtain an for residents in case of an						

02/01/2018

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.

		AND HUMAN SERVICES				FORM	02/13/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	_	(X3) DATE COM	E SURVEY PLETED
		165585	B. WING			8	C 16/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PEARL	ALLEY REHABILITA	TION AND HEALTHCARE CENTE	R	2002 CEDAR STREET MUSCATINE, IA 52761	nnd, ⇒haidir f		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD D TO THE APPROPI ICIENCY)	BE	(X5) COMPLETION DATE
F 713	of residents at an in Specifically, Reside respiratory infection distress, the facility contact for consulta interventions, result to the emergency m record showed the he was not on call a needed to fax anoth the Director of Nurs not inform the char physician coverage a census of 55 resi Findings include: 1. The email chain Vice President of P local hospital conta Executive Director implementation of a section 10.2 of the detailed 1/3/18 as t relationship at the f if he/she wanted th 12/5/17, the VP aga wanted the VP to c at 4:01 p.m., the CI would let the facility a.m., the VP contac him/her that they w and faxes from the An interview on 1/1 Corporate Regiona reported the Admin 1/5/18. The Admin	and the jeopardy. and #1 with a known history of a developed respiratory did not have a physician to ation and new orders for ting in the resident being sent oom. Resident #5's clinical on-call physician responded anymore and the facility her physician. Interview with sing (DON) revealed she did ge nurses there was no a available. The facility reported dents. dated 12/4/17 at 9:20 a.m. the hysician Services (VP) at a cted the facility Corporate (CED). The email served as a 30 day written notice under Agreements. The email he last day of physician/patient facility. The VP asked the CED e VP to inform the facility. On ain asked the CED if he/she ontact the facility. On 12/5/17 ED responded that he/she / know. On 1/5/18 at 10:50 cted the CED and informed ere still receiving phone calls facility. 0/18 at 4:58 p.m. the I Vice President (RVP) istrator called him/her on istrator reported he she on from the VP that the Medical		3 Facility ID: IA0930	If continu	ation she	et Page 2 of 9

		AND HUMAN SERVICES		o na seconda da compositiva da compositiva da compositiva da compositiva da compositiva da compositiva da compo	FORM	D: 02/13/2018 MAPPROVED D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
100	No. 1	165585	B. WING		01	1/16/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		a-61 - 25
PEARL V	ALLEY REHABILITAT	ION AND HEALTHCARE CENTE	R	2002 CEDAR STREET MUSCATINE, IA 52761		bar II i a s
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	COMPLETION DATE
F 713	Continued From pa	ne 2	F 71	3		
		vas terminated. The RVP	1 7 1	Č		
1		the CED reported the Medical				
		tive. The CED told the RVP to ector. The RVP called the				
	Medical Director wh	o informed the RVP that the				
S		ated. The RVP called a ysician coverage over the				
		found an on-call physician				1.1
	who agreed to cove	r through 1/8/18. The RVP				
		nysician on 1/8/18 to ask if nue to cover. The on-call				
	physician declined.	The RVP reported 1/17/18 is				
		covering Iowa. The RVP and the Owner to inform				
		not have physician coverage				
	for the residents on	1/9/18. The new CED and				
		uld take care of it. The RVP form them of the situation.				
		Owner to inform him/her that				
		cted. The RVP told the Owner				
	inform the state.	ay he/she could ethically not				
		0/18 at 3:20 p.m. the Director e Medical Director continued				
	to provide orders the					
	An interview on 1/0/	17 at 5:08 p.m. with the				
		17 at 5:08 p.m. with the ported he/she took call for the				
	residents at the faci	lity starting the evening of				
	1/5/18 and ended ca	all on 1/8/18 at 5:00 p.m.				
		18 at 4:45 p.m. Staff A				
		orted the DON told Staff A that				
		ng with the Medical Director sician was no longer covering.		2		
	Staff A reported all of	of the residents had the				
		their primary physician. Staff vas not informed who to call if				

Facility ID: IA0930

			AND HUMAN SERVICES				RINTED: 02/1 FORM APPF MB NO. 0938	ROVED
165585 B. WING O1/16/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2002 CEDAR STREET PEARL VALLEY REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 2002 CEDAR STREET WUSCATINE, IA 52761 USCACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) COMPLE DEFICIENCY) F 713 Continued From page 3 a resident required physician services. Staff A reported he/she planned to call the DON if there was an emergency. F 713 An interview on 1/9/18 at 4:53 a.m. the DON reported he/she found out this morning from the Administrator that the facility had no physician coverage. The DON reported the staff sent out Resident #1 with upper respiratory issues earlier today. F 713 An interview on 1/9/18 at 4:40 p.m., the Administrator reported he was working on the contract with for the new Medical Director and did not have a signed contract yet. A. According to the Admission Record dated 1/9/18 Resident #1 had diagnoses of cerebral infarct, acute upper respiratory infection, spastic Image: Additional Additionadditionadditional Additionadditional Additionadditional Additiona	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY COMPLETED		
2002 CEDAR STREET MUSCATINE, IA 52761 (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 OBSICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH OBSIC TO THE APPROPRIATE DEFICIENCY) COMMENT SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENT DEFICIENCY) F 713 Continued From page 3 a resident required physician services. Staff A reported he/she planned to call the DON if there was an emergency. F 713 An interview on 1/9/18 at 4:53 a.m. the DON reported he/she found out this morning from the Administrator that the facility had no physician coverage. The DON reported the staff sent out Resident #1 with upper respiratory issues earlier today. An interview on 1/9/18 at 4:40 p.m., the Administrator reported he was working on the contract with for the new Medical Director and did not have a signed contract yet. 2. According to the Admission Record dated 1/9/18 Resident #1 had diagnoses of cerebral infarct, acute upper respiratory infection, spastic 4. An interview on frequency infarct, acute upper respiratory infection, spastic	165585			B. WING_				
PEARL VALLEY REHABILITATION AND HEALTHCARE CENTER MUSCATINE, IA 52761 (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) COMPLE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 713 Continued From page 3 a resident required physician services. Staff A reported he/she planned to call the DON if there was an emergency. F 713 An interview on 1/9/18 at 4:53 a.m. the DON reported he/she found out this morning from the Administrator that the facility had no physician coverage. The DON reported the staff sent out Resident #1 with upper respiratory issues earlier today. F 713 An interview on 1/9/18 at 4:40 p.m., the Administrator reported he was working on the contract with for the new Medical Director and did not have a signed contract yet. A. According to the Admission Record dated 1/9/18 Resident #1 had diagnoses of cerebral infarct, acute upper respiratory infection, spastic A. According to the Admission Record dated	NAME OF	PROVIDER OR SUPPLIER	L				D	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Countinued From state of the state of the term DEFICIENCY) Countinued From page 3 a resident required physician services. Staff A reported he/she planned to call the DON if there was an emergency. F 713 F 713 An interview on 1/9/18 at 4:53 a.m. the DON reported he/she found out this morning from the Administrator that the facility had no physician coverage. The DON reported the staff sent out Resident #1 with upper respiratory issues earlier today. An interview on 1/9/18 at 4:40 p.m., the Administrator reported he was working on the contract with for the new Medical Director and did not have a signed contract yet. A. According to the Admission Record dated 1/9/18 Resident #1 had diagnoses of cerebral infarct, acute upper respiratory infection, spastic	PEARL \	VALLEY REHABILITAT	TION AND HEALTHCARE CENTE	R				
 a resident required physician services. Staff A reported he/she planned to call the DON if there was an emergency. An interview on 1/9/18 at 4:53 a.m. the DON reported he/she found out this morning from the Administrator that the facility had no physician coverage. The DON reported the staff sent out Resident #1 with upper respiratory issues earlier today. An interview on 1/9/18 at 4:40 p.m., the Administrator reported he was working on the contract with for the new Medical Director and did not have a signed contract yet. 2. According to the Admission Record dated 1/9/18 Resident #1 had diagnoses of cerebral infarct, acute upper respiratory infection, spastic 	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CO	RRECTIVE ACTION SHOULD ERENCED TO THE APPROP	BE COM	PLETION
The Minimum Data Set (MDS) assessment dated 10/4/17 revealed Resident #1 required total staff assistance with dressing, eating, toilet use personal hygiene and bathing. The Plan of Care directed the staff to provide assistance of one staff to turn and reposition in bed, transfer with a sit to stand lift, allow time to respond due to communication deficit from stroke, difficulty chewing and history of aspiration pneumonia. The Progress Notes dated 1/9/17 at 12:41 p.m. revealed Resident #1 sent to local emergency	F 713	 a resident required reported he/she pla was an emergency. An interview on 1/9, reported he/she for Administrator that the coverage. The DO Resident #1 with up today. An interview on 1/9, Administrator report contract with for the not have a signed of 2. According to the 1/9/18 Resident #1 infarct, acute upper diplegic cerebral part The Minimum Data 10/4/17 revealed Re assistance with dre personal hygiene at The Plan of Care di assistance of one sis bed, transfer with a respond due to con stroke, difficulty che pneumonia. 	physician services. Staff A inned to call the DON if there /18 at 4:53 a.m. the DON und out this morning from the he facility had no physician N reported the staff sent out oper respiratory issues earlier /18 at 4:40 p.m., the ted he was working on the e new Medical Director and did contract yet. Admission Record dated had diagnoses of cerebral respiratory infection, spastic alsy and dysphagia. Set (MDS) assessment dated esident #1 required total staff ssing, eating, toilet use nd bathing. irected the staff to provide ttaff to turn and reposition in sit to stand lift, allow time to nmunication deficit from ewing and history of aspiration s dated 1/9/17 at 12:41 p.m. #1 sent to local emergency	F 7	13			
room by ambulance due to oxygen level 78 -83% on room air. Resident #1 had a non-productive cough and wheezing in all lung fields. Resident FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: PKGY11 Facility ID: IA0930 If continuation sheet Page	FORMOMS	on room air. Resid cough and wheezin	ent #1 had a non-productive g in all lung fields. Resident	11	Facility ID: 140930	If continu	ation sheet Pag	e 4 of 9

		AND HUMAN SERVICES			FORM	: 02/13/2018 APPROVED . 0938-0391	
		DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING			
14.69	165585		B. WING	B. WING			
NAME OF F	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		/16/2018	
PEARL VALLEY REHABILITATION AND HEALTHCARE CENTER			2002 CEDAR STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 713	#1 had a temperatu Fahrenheit, pulse of 133/84. The Nursing Comm revealed Staff B em nurses comments r symptoms the last 3 signs within normal requested an order An interview on 1/1/ reported Resident # difficulty breathing a 83%. Staff B report to send Resident # more worried about breathing. Staff B re obtain an order and the nurses station of on-call physician. S the on-call physician The facility fax Activat 1:12 p.m. a fax w fax failed to send as physician's cell pho revealed no other fa physician on 1/9/18 An interview on 1/17 (Medical Records) r B who reported he/s request for cough s looked through all th was no physician re 1/9/18.	The of 97.8 degrees of 88 and blood pressure of the analysis of the physician. The revealed Resident #1 had cold a days, no temperature, vital limits and bad cough. Staff B for cough syrup as needed. 0/18 at 9:44 a.m. Staff B for cough syrup as needed. 0/18 at 9:44 a.m. Staff B for cough syrup as needed. 0/18 at 9:44 a.m. Staff B fan chest congestion, and low oxygen saturation at ted he/she did not get an order 1 out [on 1/9/18]. Staff B was resident #1's difficulty eported normally she would reported there was a note at lirecting the staff to contact the taff B reported he/she faxed n. wity Report revealed on 1/9/17 vas attempted. However, the s it was sent to the on-call ne number. The report axes sent to the on-call	F 713				
ORM CMS-25	67(02-99) Previous Versions		1 Facil	lity ID: IA0930 If con	tinuation she	et Page 5 of 9	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		165585	B. WING			C 01/16/2018		
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	CODE			
PEARL	ALLEY REHABILITAT	TION AND HEALTHCARE CENTE	R	2002 CEDAR STREET MUSCATINE, IA 52761	an. P		b.	
(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 713	reported the Admin him/her the morning physician coverage not inform the charg physician coverage same time she hea ambulance was at t #1. Staff B told the because Resident # 2. According to the 1/11/18 Resident # atherosclerotic hea heart disease, stroke embolism and cong The MDS assessm Resident #5 require of daily living. The Prothrombin Ti Normalized Ration Resident #5 had an considered 0.8 - 1.2 responded to the fa p.m. The physiciar anymore and need The staff faxed the Director on 1/11/17 dosage of 2.5 millig 2 mg every Tuesda Friday, Saturday ar any change in dosa PT/INR. The Nursing Comm revealed the new M	istrator and RVP informed g of 1/9/18 that there was no . The DON reported she did ge nurses there was no . The DON reported at the rd the ambulance sirens. The the facility to pick up Resident DON he/she called 911 #1 was in respiratory distress. Admission Record dated 5 had diagnoses of rt disease, chronic ischemic ke, history of pulmonary gestive heart failure. ent dated 12/6/17 revealed ed supervision for all activities ime and International (PT/INR) dated 1/1/8 revealed n INR of 1.2 (a normal range 2). The on-call physician exed results on 1/8/18 at 4:49 n noted he/she not on call to fax to another physician. results to the new Medical with the current Coumadin grams (mg) every Monday and by, Wednesday, Thursday, nd Sunday. The staff asked if age and if any recheck of	F 7	13				
	#5 and wrote an or	der to give Coumadin 2.5 mg		Facility ID: IA0930	If continu	ation cho	et Page 6 of 9	

		AND HUMAN SERVICES & MEDICAID SERVICES		nala na ba	FORM	: 02/13/2018 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CON	E SURVEY IPLETED
astrono a s		165585	B. WING		01/16/2018	
NAME OF PROVIDER OR SUPPLIER PEARL VALLEY REHABILITATION AND HEALTHCARE CENTER			R	STREET ADDRESS, CITY, STATE, ZIE 2002 CEDAR STREET	PCODE	
				MUSCATINE, IA 52761		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 713	every Monday Wed every Tuesday, Thu An interview on 1/17 reported he/she wa results returned from note that he/she wa send to another phy E took the fax to the concerned with no p was not returned to report the PT/INR re another doctor and taking care of it. An interview on 1/17 reported he/she too fax machine and sa noted "no longer on physician". Staff E the inform her there wa residents. Later the they could fax the o reported she left the An interview on 1/17 reported he/she did INR results until yes showed him/her. The not say anything to An interview on 1/16 reported an expecta physician with lab re faxed and awaiting DON reported it too	nesday and Friday and 2 mg insday, Saturday and Sunday. 1/18 at 11:38 a.m. Staff D s working when the PT/INR m the on-call physician with a is no longer on-call and to visician. Staff D reported Staff e DON. Staff E was ohysician coverage. The fax Staff D. Staff D passed on in eturned with a note to fax to Staff E and the DON were 1/18 at 12:00 p.m. Staff E k the PT/INR results off the w that the on-call physician call contact another called the on-call physician e was only on call over the nen called the Administrator to s no doctor covering the e Administrator told Staff E n-call physician. Staff E e fax with Staff D.	F 71	3		
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: PKGY1	1 F	acility ID: IA0930	If continuation she	et Page 7 of 9

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED	
		165585	B. WING			C 16/2018	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	DE	1 N 1	
PEARL VALLEY REHABILITATION AND HEALTHCARE CENTER			R	2002 CEDAR STREET MUSCATINE, IA 52761	a na fa		
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AP DEFICIENCY)	(X5) COMPLETION DATE		
F 713 F 947 SS=D	not document it was An interview on 1/9, Administrator report contract for new Me immediately. The facility abated to physician signed the Agreement on 1/9/1 director. The contra- duties which include coordinate medical and to provide clinic resident care. The facility alerted to contact the physicia These findings lowe Required In-Service CFR(s): 483.95(g)(1) §483.95(g)(2) Inclue training and residen §483.95(g)(3) Addred determined in nurse and facility assessments	s faxed again on 1/11/18. /18 at 5:45 p.m. the ted the facility had a signed edical Director effective the IJ on 1/9/18 when a e Medical Director Service 18 to serve as the medical act included medical director ed: being responsible to care to residents at the facility cal oversight regarding hursing staff on 1/9/18 to an/medical director if needed. ered the IJ from an "L" to an E. e Training for Nurse Aides 1)-(4) ad in-service training for nurse nust- ufficient to ensure the ence of nurse aides, but must hours per year. de dementia management at abuse prevention training. ess areas of weakness as a aides' performance reviews nent at § 483.70(e) and may needs of residents as	F 7	13			
FORM CMS-2	567(02-99) Previous Versions		11	Facility ID: IA0930 If	continuation she	et Page 8 of 9	

DEPARTMENT OF HEALTH AND HUMAN SERVICES							02/13/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165585	B. WING		a	C 01/16/2018	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL V	ALLEY REHABILITAT	ION AND HEALTHCARE CENTER	R	0.000	IUSCATINE, IA 52761		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	2	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 947	 §483.95(g)(4) For n to individuals with c address the care of This REQUIREMEN by: Based on record refacility failed to ensurin-service training for The facility reported Findings include: 1. The facility hired position of Nurse Air records from 9/20/1 had zero in-service 2. The facility hired position of Nurse Air records from 8/28/1 had zero in-service 3. The facility hired position of Nurse Air records from 5/3/17 had 2 in-service how During an interview Administrator reported she started 12/18/18 conducted Administrator added 	 Staff F on 9/20/17 for the de. Review of the in-service 7 to 12/31/17 revealed Staff G hours. 	F 94	47			

Facility ID: IA0930

If continuation sheet Page 9 of 9

Pearl Valley Rehab - Muscatine 2002 Cedar Street Muscatine, IA 52761 Phone: 563-264-2023

> Provider's Plan of Correction Date Survey Completed: January 16, 2018

F 000: Initial Comments:

The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with State and Federal regulations, the facility has taken or will take the following actions set forth in this plan of correction.

F713 Availability of physicians for emergency care:

The facility does and will continue to ensure all patients, including #1 and #5, remain in a facility that provides adequate availability of physicians for emergency care and medical treatment.

All residents are at an increased risk of an adverse outcome due to the absence of a medical director.

On 1-9-2018, a new medical director was contracted immediately, at 5:45 pm, with the facility. All residents in the facility had access to a physician/medical director as of 1-9-18. Residents, and families, were notified of the new medical director change.

The facility does and will continue to ensure all patients, including #1 and #5, have appropriate access to medical services.

The administrator or designee will complete monthly audits to ensure patients have appropriate access to medical director. All findings will be submitted to the Quality Assurance Committee for review.

F947 Required in-service training for nurse aides:

The facility does and will continue to ensure all CNA's have the proper 12 hours of continuing education per year according to \$483.95(g)(1).

Under new administration, a program was established December 21, 2017 regarding monthly in-services/staff training. All staff are required to attend an all staff monthly meeting the 3rd Thursday of each month. Employees will sign in and a copy of said sign in sheet, along with any and all learning materials, will be put in their personnel files. The Administrator will also keep a

copy of the sign in sheet, and learning materials, in an In-Service binder in the Administrator's office.

As added education, the facility will be implementing the Relias Learning Program. Each employee will be required to complete the monthly scheduled trainings via computer. Once completed, a copy of their Certificate of Completion will be printed and kept in their personnel file. Expected launch of this program will be February 1, 2018.

The Administrator/Human Resources Director will complete monthly audits for the first 6 months, after the launch of the program, to ensure that employees are completing their monthly Relias training as scheduled.

All findings will be submitted to the facility Quality Assurance Committee.

Date of Compliance: January 17, 2018.