|                          | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA.<br>IDENTIFICATION NUMBER:  |                     | LE CONSTRUCTION  |         | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|---------------------|--|---------|-------------------------------|--|
|                          | Genaletion   |   | A. BUILDING         | · · · · · · · · · · · · · · · · · · ·  |         | WFLETED                       |  |
|                          | · >  | 165453  | B. WING             |  |         | /03/2018                      |  |
| iame of i                | PROVIDER OR SUPPLIER   |   | 1                   | STREET ADDRESS, CITY, STATE, ZIP COD   | Ē       |                               |  |
| PEARL V                  | ALLEY REHABILITA   | TION & HEALTHCARE CENTER (  |                     | 01 E POLK ST<br>WASHINGTON, IA 52353   |         |                               |  |
| (X4)-ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETIC<br>DATE     |  |
| F_000                    | INITIAL COMMEN   | ſS  | F 000               |  |         |                               |  |
|                          | Correction<br>Date   | -7-18   |                     |  |         |                               |  |
| m                        | recertification and S<br>investigation of con  | encies relate to the annual<br>State Licensure Survey and<br>plaints 79633-C and 78972-C<br>S-18 thru 11-29-18. Both<br>t substantiated.                                      |                     |  |         |                               |  |
|                          | See code of Federa<br>483, Subpart B-C.  | I Regulations (42 CFR) Park   |                     |  |         |                               |  |
|                          | Amended 1/2/19 by<br>Notice Requiremen<br>CFR(s): 483.15(c)(3  | ts Before Transfer/Discharge  | F 623               | •  |         |                               |  |
|                          | resident, the facility<br>(i) Notify the resider<br>representative(s) of   | esfers or discharges a<br>must-<br>it and the resident's<br>the transfer or discharge and   |                     | 2  |         |                               |  |
|                          | language and mann<br>facility must send a<br>representative of the<br>Long-Term Care On<br>(ii) Record the rease | move in writing and in a<br>ber they understand. The<br>copy of the notice to a<br>e Office of the State<br>nbudsman.<br>ons for the transfer or<br>ident's medical record in |                     |  |         |                               |  |
|                          | accordance with par<br>and   | ragraph (c)(2) of this section;<br>tice the items described in  |                     |  |         |                               |  |
|                          |  | g of the notice.<br>ed in paragraphs (c)(4)(ii) and<br>, the notice of transfer or  |                     |  |         |                               |  |

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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.

|                         | OF DEPOSION           | IDENTIFICATION NUMBER:  |                     | OLI, BUILDING  |                                       |                          |  |
|-------------------------|-----------------------|---|---------------------|--|---------------------------------------|--------------------------|--|
|                         |                       | 165453  | . B, WING           | 1999 - 1999 - 1999 - 1997 - 19 | . 12                                  | 2/03/2018                |  |
| ME OF I                 | PROVIDER OR SUPPLIER  |   |                     | REET ADDRESS, CITY, STATE, Z   | · · · · · · · · · · · · · · · · · · · |                          |  |
|                         |                       |   | 60                  | 1 E POLK ST  |                                       |                          |  |
| EARLI                   |                       | TION & HEALTHCARE CENTER  | U W                 | ASHINGTON, IA 52353  |                                       |                          |  |
| X4) ID<br>'REFIX<br>TAG | (EACH DEFICIENC       | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC   | TON SHOULD BE                         | (X5)<br>COMPLETI<br>DATE |  |
| F 623                   | Continued From p      | age 1   | F 623               |  |                                       |                          |  |
|                         | 1                     | l under this section must be  | 1 020               | ,  |                                       |                          |  |
|                         |                       | y at least 30 days before the   |                     |  |                                       |                          |  |
|                         | resident is transfer  |   |                     |  |                                       |                          |  |
|                         |                       | made as soon as practicable   |                     |  |                                       |                          |  |
|                         | before transfer or    | discharge when-   |                     | • •  |                                       |                          |  |
|                         |                       | ndividuals in the facility would  |                     |  |                                       |                          |  |
|                         |                       | der paragraph (c)(1)(i)(C) of   |                     |  |                                       |                          |  |
|                         | this section;         |   |                     |  |                                       |                          |  |
|                         |                       | ndividuals in the facility would  |                     |  |                                       |                          |  |
|                         | this section;         | nder paragraph (c)(1)(i)(D) of  |                     |  |                                       |                          |  |
|                         |                       | health improves sufficiently to   |                     |  |                                       |                          |  |
|                         |                       | ediate transfer or discharge,   |                     |  |                                       |                          |  |
|                         |                       | c)(1)(i)(B) of this section;  |                     |  |                                       |                          |  |
|                         |                       | transfer or discharge is  |                     |  |                                       |                          |  |
|                         |                       | ident's urgent medical needs,   |                     |  |                                       |                          |  |
|                         |                       | c)(1)(i)(A) of this section; or   |                     |  |                                       |                          |  |
|                         |                       | not resided in the facility for 30  |                     |  |                                       |                          |  |
|                         | days.                 |   |                     |  |                                       |                          |  |
|                         | 8483 15(c)(5) Con     | tents of the notice. The written  |                     |  |                                       |                          |  |
|                         |                       | paragraph (c)(3) of this section  |                     |  |                                       |                          |  |
|                         | must include the fo   |   |                     |  |                                       |                          |  |
| :                       | (i) The reason for    | transfer or discharge;  |                     |  |                                       |                          |  |
|                         | (ii) The effective da | ate of transfer or discharge;   |                     |  |                                       |                          |  |
|                         |                       | which the resident is   |                     |  |                                       |                          |  |
|                         | transferred or disc   |   |                     |  |                                       |                          |  |
|                         |                       | the resident's appeal rights,   |                     |  |                                       |                          |  |
|                         |                       | e, address (mailing and email),   |                     |  |                                       |                          |  |
|                         |                       | nber of the entity which<br>lests; and information on how                             |                     |  |                                       |                          |  |
|                         |                       | I form and assistance in  |                     |  |                                       |                          |  |
|                         |                       | n and submitting the appeal   |                     |  |                                       |                          |  |
|                         | hearing request;      |   |                     |  |                                       | 1                        |  |
|                         |                       | ress (mailing and email) and  |                     |  |                                       |                          |  |
|                         | telephone number      | of the Office of the State  |                     |  |                                       |                          |  |
|                         | Long-Term Care O      |   |                     | · · · · · · · · · ·  |                                       | -                        |  |
|                         | (vi) For nursing fac  | ility residents with intellectual   | -                   |  |                                       |                          |  |
| 4                       |                       |   |                     |  |                                       | 1                        |  |

|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                      |         |  |              | FORM      | 01/09/2019<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|----------------------|---------|--|--------------|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1                    |         | CONSTRUCTION   |              |           | E SURVEY<br>IPLETED                 |
|                          |   | 165453   | B. WING              |         |  |              | 12/       | 03/2018                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                      |         | REET ADDRESS, CITY, STATE, Z   | IP CODE      | •         |                                     |
| PEARL V                  | ALLEY REHABILITAT   | ION & HEALTHCARE CENTER (  | D I                  |         | I E POLK ST<br>ASHINGTON, IA 52353   |              |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST 8E PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>· TAG |         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | FION SHOULD  | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 623                    | disabilities, the mail<br>telephone number of<br>the protection and a<br>developmental disa<br>C of the Developmental<br>and Bill of Rights Ac<br>codified at 42 U.S.C<br>(vii) For nursing faci<br>disorder or related of<br>email address and t<br>agency responsible<br>advocacy of individu<br>established under th<br>for Mentally III Indivi<br>§483.15(c)(6) Chan<br>If the information in<br>effecting the transfe<br>must update the reo<br>as practicable once<br>becomes available.<br>§483.15(c)(8) Notice<br>in the case of facility<br>the administrator of<br>written notification p<br>to the State Survey. | disabilities or related<br>ing and email address and<br>of the agency responsible for<br>advocacy of individuals with<br>bilities established under Part<br>ental Disabilities Assistance<br>et of 2000 (Pub. L. 106-402,<br>5. 15001 et seq.); and<br>lity residents with a mental<br>lisabilities, the mailing and<br>elephone number of the<br>for the protection and<br>lals with a mental disorder<br>ne Protection and Advocacy<br>duals Act.<br>ges to the notice.<br>the notice changes prior to<br>r or discharge, the facility<br>ipients of the notice as soon<br>the updated information | Fe                   | 523     | i .  |              |           |                                     |
|                          | well as the plan for t<br>relocation of the res<br>483.70(I).<br>This REQUIREMEN<br>by:<br>Based on staff inter   | esident representatives, as<br>he transfer and adequate<br>idents, as required at §<br>IT is not met as evidenced<br>view and clinical record<br>iled to send a notice of the  |                      |         |  | •            | -         |                                     |
|                          | discharge to the official   | ce of the State Long-Term<br>or 3 of 3 residents reviewed  | 1.                   | Facilii | ly ID: 1A0948  | if continuat | ion sheet | Page 3 of 40                        |

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|                          | FCORRECTION   | IDENTIFICATION NUMBER:   |                     | ING   | COMPLETED            |
|--------------------------|---|--|---------------------|---|----------------------|
|                          |   | 165453   | B. Wing             |   | 12/03/2018           |
|                          | PROVIDER OR SUPPLIER  | ION & HEALTHCARE CENTER C  | , ,                 | STREET ADDRESS, CITY, STATE, ZIP CC<br>601 E POLK ST<br>WASHINGTON, IA 52353                    |                      |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIJ<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE COMPLÉTION |
| F 623                    | <ul> <li>37 residents.</li> <li>Findings include:</li> <li>1. The Minimum D<br/>10/26/18, listed Res<br/>moderately impaire<br/>following diagnoses<br/>schizophrenia, delir<br/>aphasia (the loss of<br/>express speech).</li> <li>A progress note ent<br/>resident transferred<br/>room.</li> <li>A progress note ent<br/>resident returned to</li> <li>The facility lacked of<br/>of Ombudsman not<br/>hospital.</li> <li>The undated facility<br/>the ombudsman mot<br/>transfers/discharges</li> <li>During an interview<br/>consultant stated th</li> </ul> | ata Set (MDS), dated<br>sident #30's cognition as<br>d. The MDS listed the<br>for Resident #30:<br>ium, anxiety disorder, and<br>ability to understand or<br>ry, dated 10/19/18, stated the<br>to the hospital emergency<br>ry, dated 10/22/18, stated the<br>facility.<br>locumentation of notification<br>fication of the transfer to the<br>policy directed staff to notify<br>onthly of resident<br>s monthly.<br>on 11/28/18, the nurse<br>e facility did not notify the<br>sfers and stated they | F 6                 | · · · · · · · · · · · · · · · · · · ·   |                      |
|                          | #41 had diagnoses<br>hypo-osmolality, hyp<br>hypothyroidism, GE   | 10/26/18 revealed Resident<br>that included:<br>conatremia (low sodium),<br>RD (gastric reflux or<br>ision, weakness, and difficulty   |                     |   | · · · · ·            |

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If continuation sheet Page 4 of 40

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|                          |   | AND HUMAN SERVICES   |                   |     |  | FORM                          | : 01/09/2019<br>APPROVED<br>. 0938-0391 |  |
|--------------------------|---|--|-------------------|-----|--|-------------------------------|---|--|
| STATEMEN                 | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |   |  |
|                          |   | 165453   | B. WING           |     |  |                               | 03/2018                                 |  |
|                          | PROVIDER OR SUPPLIER  | TION & HEALTHCARE CENTER (   | )<br>)            | 6   | NTREET ADDRESS, CITY, STATE, ZIP CODE<br>01 E POLK ST<br>VASHINGTON, IA 52353                                    |                               |   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>( MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE              |  |
| F 623                    | Continued From pa   | ge 4   | F                 | 323 |  |                               |   |  |
|                          | any information reg<br>Ombudsman upon<br>discharge from the<br>On 11/29/18, the Ac<br>confirmed the facilit   | Iministrator for the facility  |                   |     |  |                               |   |  |
|                          | 42 had diagnoses the<br>respiratory failure, of<br>rheumatoid arthritis<br>Resident # 42's me<br>any information on<br>discharge to the On  | 09/12/18 revealed Resident #<br>hat included asthma,<br>lysphasia, heart disease,<br>, and shortness of breath.<br>dical record failed to provide<br>the notification of the<br>nbudsman.  |                   |     | -<br>-   |                               |   |  |
| F 656<br>SS=D            | Guidelines directed<br>Ombudsman of res<br>a monthly basis.<br>Develop/Implement  | staff to notify the<br>ident transfers/discharges on<br>Comprehensive Care Plan  | Fe                | 556 |  |                               |   |  |
| -                        | §483.21(b)(1) The f<br>implement a compr<br>care plan for each r<br>resident rights set fo<br>§483.10(c)(3), that i<br>objectives and time<br>medical, nursing, ar<br>needs that are iden | hensive Care Plans<br>acility must develop and<br>ehensive person-centered<br>esident, consistent with the<br>orth at §483.10(c)(2) and<br>includes measurable<br>frames to meet a resident's<br>and mental and psychosocial<br>tified in the comprehensive<br>comprehensive care plan must<br>ang - |                   |     |  |                               |   |  |

Facility ID: IA0948

If continuation sheet Page 5 of 40

| AND PLAN C               | FCORRECTION   | IDENTIFICATION NUMBER:   |                     | 3 <u></u>   | COMPLETED         |  |
|--------------------------|---|--|---------------------|---|-------------------|--|
| -                        |   | 165453   | B. WING             |   | 12/03/2018        |  |
|                          | PROVIDER OR SUPPLIER  | TION & HEALTHCARE CENTER C   | <b>,</b> .          | STREET ADDRESS, CITY, STATE, ZIP CODE<br>601 E POLK ST<br>WASHINGTON, IA 52353                          |                   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE COMPLETION |  |
| F 656                    | or maintain the resi<br>physical, mental, ar<br>required under §48<br>(ii) Any services that<br>under §483.24, §48<br>provided due to the<br>under §483.10, incl<br>treatment under §4<br>(iii) Any specialized<br>rehabilitative servic<br>provide as a result<br>recommendations.<br>findings of the PAS,<br>rationale in the resident's<br>provide as a result<br>recommendation w<br>resident's represent<br>(A) The resident's g<br>desired outcomes.<br>(B) The resident's g<br>desired outcomes.<br>(B) The resident's p<br>future discharge. Fa<br>whether the resider<br>community was ass<br>local contact agenc<br>entities, for this pury<br>(C) Discharge plans<br>plan, as appropriate<br>requirements set fo<br>section.<br>This REQUIREMEN<br>by:<br>Based on observat<br>and staff interview,<br>specific areas of cal<br>and potential for or<br>comprehensive care | t are to be furnished to attain<br>dent's highest practicable<br>ad psychosocial well-being as<br>3.24, §483.25 or §483.40; and<br>at would otherwise be required<br>3.25 or §483.40 but are not<br>resident's exercise of rights<br>uding the right to refuse<br>83.10(c)(6).<br>services or specialized<br>es the nursing facility will<br>of PASARR<br>If a facility disagrees with the<br>ARR, it must indicate its<br>dent's medical record.<br>with the resident and the<br>tative(s)-<br>roals for admission and<br>reference and potential for<br>acilities must document<br>it's desire to return to the<br>essed and any referrals to<br>ies and/or other appropriate<br>pose.<br>in the comprehensive care<br>in accordance with the<br>rth in paragraph (c) of this<br>IT is not met as evidenced<br>ion, clinical record review,<br>the facility falled to address<br>re regarding activities, pain,<br>actual pressure sores on the<br>plan for 3 of 12 residents<br>#1, #19, and #22). The facility | F 65                | 6   |                   |  |
| 1                        |   |  |                     |   | 1 1               |  |

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If continuation sheet Page 6 of 40

| CENTERS FOR MEDICAR   | HAND HUMAN SERVICES   |                      | 、  |            | FORM | 01/09/201<br>APPROVEI<br>0938-039 |
|---|---|----------------------|--|------------|------|-----------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1                    | PLE CONSTRUCTION G   |            |      | SURVEY<br>PLETED                  |
|   | 165453  | B. WING              | ·  |            | 12/0 | 3/2018                            |
| NAME OF PROVIDER OR SUPPLIER  |   |                      | STREET ADDRESS, CITY, STATE, Z   | IP CODE    |      | · · ·                             |
| PEARL VALLEY REHABILITA   | TION & HEALTHCARE CENTER (  |                      | 601 E POLK ST<br>WASHINGTON, IA 52353  |            |      | _                                 |
| PREFIX (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | 'ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD | BE   | (X5)<br>COMPLETION<br>DATE        |
| assessment tool d<br>had diagnoses of h<br>pneumonia, aphas<br>non-traumatic intra<br>unspecified and dy<br>Mental Status (BIM<br>MDS documented<br>dependent on 2 sta<br>which included bed<br>toilet use, and pers<br>assessment (CAA)<br>included activities,<br>feeding tube, and p   | e Minimum Data Set (MDS)<br>ated 8-11-2018, Resident #1<br>nemiplegia, hypertension,<br>ia (difficulty or inability, stroke,<br>accrebral hemorrhage,<br>ysphasia. A Brief Interview for<br>AS) was not assessed. The<br>the resident as totally<br>aff for all activities of daily living<br>d mobility, transfers, dressing,<br>sonal hygiene. The care area<br>) identified focus areas that<br>psychosocial well-being,<br>bain.  | F 65                 | 3  |            |      |                                   |
| Nurse Consultant a<br>activities addresse<br>and reported a new<br>worked for 3 weeks<br>former activity direct<br>Nurse Consultant a<br>quarterly unless th<br>falls, urinary tract in<br>In an interview with<br>09:04 AM, she veri<br>on any activities or<br>with Resident #1. T<br>former activity direct<br>resident by reading<br>no documentation | 11-27-18 at 11:40 am, the<br>acknowledged the lack of<br>d on the resident care plan,<br>v activity staff member had<br>s attempting to catch up as the<br>ctor left in October 2018. The<br>stated care plans are updated<br>here is a reason specific i.e.:<br>infection.<br>The Administrator on 11/28/18<br>fied the lack of documentation<br>any staff of activity staff 1:1<br>The Administrator reported the<br>ctor had engaged with the<br>to him or providing music, but<br>of that was provided by the<br>strator reported the new |                      | acility ID: IA0948   |            |      | Page 7 of 4                       |

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Event ID: CCO211

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Facility ID: IA0948

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|                          | OF CORRECTION  | IDENTIFICATION NUMBER:   |                    | 1994  |                                 | СОМ | PLETED                     |
|--------------------------|--|--|--------------------|---|---------------------------------|-----|----------------------------|
|                          |  | 165453   | B. WING            |   |                                 | 12/ | 03/2018                    |
|                          | PROVIDER OR SUPPLIER   | TION & HEALTHCARE CENTER C   |                    | STREET ADDRESS, CITY, STAT<br>601 E POLK ST<br>WASHINGTON, IA 52353 | E, ZIP CODE                     |     |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | PROVIDER'S PLAN<br>(EACH CORRECTIVE<br>CROSS-REFERENCED<br>DEFICI   | ACTION SHOULD<br>TO THE APPROPF | BE  | (X5)<br>Completion<br>Date |
| F 656                    | weeks ago and pla<br>activity or activity I<br>2. According to the<br>#22 had diagnose<br>difficulty walking, a<br>The MDS docume<br>limited assist of 1<br>assist of 1 staff for<br>toilet use, and per<br>documented Resid<br>assistance of 2 sta<br>totally dependent of<br>identified the resid<br>Mental Status) sco<br>cognition and docu<br>risk of developing<br>During an observa<br>the surveyor walke<br>breakfast table an<br>surveyor she had a<br>and was in pain. T<br>room chair and ha<br>During an observa<br>the resident sat in<br>her in the activity r<br>observations revea<br>room chair at 8:55<br>During an observa<br>staff C CNA (Certi<br>the room as the re<br>resident told Staff<br>resident stood up a<br>sized red area on t<br>appeared to be mis | arted working at the facility 3<br>anned to address the lack of<br>og for the resident.<br>MDS dated 10/3/18, Resident<br>is that included diabetes,<br>and chronic kidney disease.<br>Inted the resident required<br>staff for eating and extensive<br>transfers, walking, dressing,<br>sonal hygiene. The MDS also<br>dent #22 required extensive<br>aff for bed mobility, and was<br>on 1 staff for bathing. The MDS<br>ent's BIMS (Brief Interview for<br>ore as 14 of 15, indicating intact<br>umented the resident was at<br>pressure ulcers.<br>tion on 11/27/18 at 8:05 a.m.,<br>ad by the resident sitting at the<br>d the resident sat in a dining<br>d no pad under her.<br>tion on 11/27/18 at 8:22 a.m.,<br>a chair without a cushion under | F 6                | 56  |                                 |     |                            |

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If continuation sheet Page 8 of 40

|                          |   | AND HUMAN SERVICES  |                                       |   |               | FORM | 01/09/2019<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|---------------------------------------|---|---------------|------|-------------------------------------|
|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                                       |   |               |      | E SURVEY<br>PLETED                  |
|                          |   | 165453  | B. WING                               | · · · · · · · · · · · · · · · · · · ·                             |               | 12/  | 03/2018                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |   | 1 ·                                   | STREET ADDRESS, CITY, STAT  | E, ZIP CODE   |      |                                     |
| PEARL \                  | ALLEY REHABILITA  | TION & HEALTHCARE CENTER (  | ) I                                   | 601 E POLK ST<br>WASHINGTON, 1A 52353                             |               |      |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ITEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                   | PROVIDER'S PLAN<br>(EACH CORRECTIVE<br>CROSS-REFERENCED<br>DEFICI | ACTION SHOULD | BE   | (X5)<br>Completion<br>Date          |
| F 656                    | Continued From pa   | ge 8  | F 656                                 | 3   |               |      |                                     |
| •                        | entire right buttock<br>Staff C mixed A and<br>(ointments used to<br>applied this to the a<br>back down in the re-<br>would tell the nurse<br>an order for somether<br>treatment). The re-<br>bad she could not so<br>resident's recliner w   | was reddish purplish in color.<br>I D Ointment and Peri Guard<br>treat skin irritation) and<br>rea, then the resident sat<br>cliner. Staff A stated she<br>and they would try to obtain   |                                       |   |               |      |                                     |
|                          | cushion present. F<br>stated to the survey<br>how long the reside<br>was approximately  | ollowing the cares, Staff C<br>for she was not exactly sure<br>ont had the area but thought is<br>1 week.   |                                       |   |               |      |                                     |
|                          | During an observati<br>the resident sat in a<br>no cushion under h  | ion on 11/27/18 at 12:30 p.m.,<br>a chair at the lunch table with<br>er.  |                                       |   |               |      |                                     |
| -                        |   | ion on 11/27/18 at 2:30 p.m.,<br>er recliner. The recliner did<br>a cushion in it.  |                                       |   |               |      |                                     |
|                          | Staff D CNA assisted<br>from her recliner as<br>Practical Nurse) me<br>the resident's right I<br>cm(centimeter) x 1.<br>measuring 0.5 cm.<br>resident had somet<br>(11/26/18) when she<br>not open at that tim<br>area, the resident s<br>had a visible, thick I<br>stated the black cus<br>cushion used to pre | on on 11/28/18 at 8:45 a.m.,<br>ad the resident to stand up<br>Staff A LPN (Licensed<br>easured a red open wound on<br>buttock, which measured 1<br>25 cm with a thin red trail<br>Staff D commented the<br>hing on her bottom on Monday<br>e took care of her, but it was<br>e. After Staff A measured the<br>at down in the recliner which<br>black cushion in it. Staff A<br>shion was a Roho (a thick<br>event and treat pressure<br>ok out the "gel one" yesterday | · · · · · · · · · · · · · · · · · · · |   | •             |      |                                     |

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If continuation sheet Page 9 of 40

| ND FLAN U                | FCORRECTION  | IDENTIFICATION NUMBER:  | A. BUILDI                             | NG   | COMPLETED                        |  |  |
|--------------------------|--|---|---------------------------------------|--|----------------------------------|--|--|
| •                        |  | 165453  | B. WING                               |  | 12/03/2018                       |  |  |
|                          | ROVIDER OR SUPPLIER  | ATION & HEALTHCARE CENTER (   | STREET ADDRESS, CITY, STATE, ZIP CODE |  |                                  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG                   | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | V SHOULD BE COMPLETION           |  |  |
| F 656                    | as she pointed to  | age 9<br>the counter. On the counter<br>kimately 1 cm thick) yellow gel   | F 6                                   | 56   |                                  |  |  |
|                          | resident had an o<br>approximately 1 c   | n. progress note stated the<br>pen area on the right buttocks<br>m round, superficial and the<br>discomfort when sitting.   | -                                     |  |                                  |  |  |
|                          | order for an Optifo  | n progress note listed an<br>bam border dressing (a foam<br>ght buttocks applied every other<br>d.  |                                       |  |                                  |  |  |
|                          | to discontinue the<br>begin Calmoseptin<br>to treat skin irritati<br>in the chair. The<br>documentation of | n. progress note listed an order<br>Optifoam border dressing and<br>ne ointment (an ointment used<br>on) and utilize a Roho cushion<br>progress note lacked any<br>an assessment of the wound<br>he area as healed. |                                       |  |                                  |  |  |
|                          | had a question ma<br>lacerations, lesion<br>documented the lo  | ed "Weekly Skin Assessment"<br>arked "yes" for "open cuts,<br>s, or skin tears" and<br>ocation as to the right buttocks<br>facility discontinued the<br>'18.  |                                       |  | •                                |  |  |
|                          | resident reported  | a.m. progress note stated the<br>bain in her bottom and the<br>hysician with regard to a<br>J.  |                                       |  |                                  |  |  |
|                          | area between the   | any further assessments of the dates of 9/21/18 and 11/28/18 survey week).  |                                       |  |                                  |  |  |
|                          | Review of the Octo   | ober TAR (Treatment   |                                       |  |                                  |  |  |
| RM CMS-25                | 37(02-99) Previous Version   | s Obsolete Event ID: CCO21  | 1                                     | Facility ID: 1A0948 If c   | continuation sheet Page 10 of 40 |  |  |
|                          |  |   | \$                                    |  |                                  |  |  |

| DEPARTMENT  | OF HEALTH AND HUMAN | SERVICES |
|-------------|---------------------|----------|
| CENTERS FOR | MEDICARE & MEDICAID | SERVICES |

# PRINTED: 01/09/2019 FORM APPROVED

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| CENTERSFOR MEDICARE<br>STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:  | 1                                     |     | E CONSTRUCTION   | (X3) DAT   | <u>0938-039</u><br>E SURVEY<br>IPLETED |  |  |
|--|---|--|---------------------------------------|-----|--|------------|--|--|--|
|  |   | 165453   | B. WINC                               | -   | · · · · · · · · · · · · · · · · · · ·  | 12/03/2018 |  |  |  |
|  | PROVIDER OR SUPPLIER  | <u></u>  | STREET ADDRESS, CITY, STATE, ZIP CODE |     |  |            |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAC                     |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) BE       | (X5)<br>Completion<br>Date             |  |  |
| F 656  | Administration Rec<br>received Calmosep<br>from 10/8/18 - 10/2<br>Review of the Octo<br>revealed the facility<br>skin treatment to th<br>- 11/28/18.<br>Record revealed no<br>notified the physicia<br>period of 11/3/18 w<br>documented an ope<br>(11/26/18).<br>The Braden Scale to<br>Risk, dated 10/9/18<br>low risk for the deve | for Predicting Pressure Sore<br>8, stated the resident<br>when and November TARS<br>v lacked documentation of a<br>ne right buttocks from 10/21/18<br>b information to indicate staff<br>an of an open area from the<br>then facility charting<br>en area and the survey week<br>for Predicting Pressure Sore<br>3, stated the resident was at<br>elopment of pressure ulcers.   | F                                     | 856 |  |            |  |  |  |
|  | resident was at risk<br>integrity related to s<br>stated the resident<br>intact skin by the re-<br>entries directed sta<br>regarding measure<br>encourage good nu-<br>identify potential ca<br>Care plan entries, in<br>avoid scratching an<br>from excessive mo<br>for the treatment of<br>dry, and monitor/do                       | revised 5/9/18, stated the<br>c for impairment to skin<br>scratching and immobility and<br>would maintain clean and<br>eview date. Additional 5/9/18<br>ff to educate the resident<br>s to prevent skin injury,<br>utrition and hydration, and<br>jusative factors.<br>nitiated 8/2/17, instructed to<br>not keep hands and body parts<br>isture, follow facility protocols<br>injury, keep skin clean and<br>boument location, size, and<br>jury and report abnormalities |                                       |     |  |            |  |  |  |
|  | The care plan lacks   | ed further specific interventions cushion for the chair)   |                                       |     |  |            |  |  |  |

FORM CMS-2667(02-99) Previous Versions Obsolete

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Facility ID: IA0948

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If continuation sheet Page 11 of 40

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|                          |   | 165453  | B. WING             |  | 4010010010                    |
|--------------------------|---|---|---------------------|--|-------------------------------|
|                          |   |   | 1                   | STREET ADDRESS, CITY, STATE, ZIP CC<br>601 E POLK ST   | <b>12/03/2018</b><br>DDE      |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY S<br>(EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)           | ID<br>PREFIX<br>TAG | WASHINGTON, IA 52353<br>PROVIDER'S PLAN OF CORI<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE COMPLETIO           |
| F 656                    | implemented by it<br>skin breakdown a<br>resident had a cur<br>previous open are<br>During an intervie<br>DON(Director of N<br>report skin concer<br>should call the ph<br>treatment. She st<br>assessments wee<br>stated staff should<br>with open wounds<br>resident's skin con-<br>care plan.<br>3. According to th<br>#19 had diagnose<br>chronic pain, and<br>resident required is<br>mobility, transfers<br>personal hygiene,<br>assistance for dre<br>extensive assistant<br>MDS listed the res-<br>indicating intact co-<br>had occasional pa<br>limited day-to-day<br>resident rated the<br>with "0" being no p<br>pain imaginable.<br>During an interview<br>10:00 a.m., the res-<br>and had arthritis. | he facility to prevent and treat<br>nd lacked documentation the<br>rent open area or a history of |                     |  |                               |
| M CMS-25                 | 57(02-99) Previous Version  | s Obsolete Event ID: CCO21  | 1                   | Facility ID: IA0948 If co  | ntinuation sheet Page 12 of 4 |
| -                        |   |   |                     |  |                               |
|                          |   |   |                     |  |                               |
|                          |   |   |                     | `  | <i>}</i>                      |

|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |   |                    | E SURVEY                  |
|--------------------------|---|---|---------------------|---|--------------------|---------------------------|
|                          |   | 165453  | B. WING             |   | 12                 | /03/2018                  |
| NAME OF F                | PROVIDER OR SUPPLIER  | · · · ·   | s                   | TREET ADDRESS, CITY, STATE, ZIP   |                    |                           |
| PEARL V                  | ALLEY REHABILITA  | TION & HEALTHCARE CENTER (  | ו ר                 | 01 E POLK ST<br>VASHINGTON, IA 52353  |                    |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI<br>DEFICIENCY) | N SHOULD BE        | (X5)<br>COMPLETIO<br>DATE |
| F 656                    | resident grimaced the chair. She stal                           | age 12<br>v on 11/27/18 at 8:39 a.m., the<br>while walking from her bed to<br>ed staff did give her pain<br>hey helped, but not completely. | · F 656             |   |                    |                           |
|                          | She stated the more<br>A pain assessment<br>resident had pain " | t, dated 11/6/18, stated the<br>almost constantly" over the last<br>ne pain as a "4" on a scale of  |                     |   |                    |                           |
| -                        | documentation of t  | ent care plan lacked<br>he resident's pain and lacked<br>agarding interventions utilized  |                     | -   |                    |                           |
|                          | Development Proc<br>develop a compret                           | y policy, "MDS/Care Plan<br>ess" stated the facility would<br>nensive, individualized plan of<br>ent including medical, physical,<br>ds.    |                     |   |                    |                           |
|                          | DON stated pain sl<br>plan and care plan<br>working to improve  | Meet Professional Standards   | F 658               |   |                    | -                         |
|                          | The services provid<br>as outlined by the o<br>must-            | prehensive Care Plans .<br>ded or arranged by the facility,<br>comprehensive care plan,<br>al standards of quality.                         |                     |   |                    |                           |
|                          | This REQUIREME<br>by:<br>Based on observa                       | NT is not met as evidenced<br>tion, clinical record review, and<br>a facility staff failed to follow  |                     |   |                    | × ·                       |
| M CMS-256                | 67(02-99) Previous Versions                                     | Obsolete Event ID: CCO21  | 1 Fac               | illy ID: IA0948 If  | continuation sheet | Page 13 of                |

| ) plan u                 | FCORRECTION   | IDENTIFICATION NUMBER:  | A. BUILDING         |   | CON                                   | WPLETED                  |
|--------------------------|---|---|---------------------|---|---------------------------------------|--------------------------|
|                          |   | 165453  | B. WING             | · · · · · · · · · · · · · · · · · · ·   | 12                                    | /03/2018                 |
| AME OF I                 | PROVIDER OR SUPPLIER  |   | 1 .                 | REET ADDRESS, CITY, STATE, ZIP CO   |                                       |                          |
| EARL V                   | ALLEY REHABILITAT   | ION & HEALTHCARE CENTER   | 0                   | E POLK ST<br>ASHINGTON, IA 52353  |                                       |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | FEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                             | (X5)<br>COMPLETI<br>DATE |
| F 658                    | G tube medications<br>the sample. (Reside<br>reported a census of<br>Findings include:<br>1. According to the<br>assessment tool dat<br>diagnoses of hemip<br>pneumonia, aphasia<br>intracerebral hemor<br>(difficulty speaking).<br>status was not asse<br>the resident as total<br>bed mobility, transfe<br>personal hygiene. | rds of medication<br>of 1 residents reviewed with<br>, and for 1 of 12 residents in<br>onts #1, #22). The facility<br>of 37 residents.<br>Minimum Data Set (MDS)<br>ted 8/11/18, Resident #1 had  | F 658               |   |                                       |                          |
|                          | A crushed the follow<br>Tylenol 325 milligrar<br>Baclofen 20 mg eve<br>Oxycodone every 6  | ns (mg) 2 tabs four times day<br>ry 6 hours   |                     | ·   |                                       |                          |
|                          | a barrier for supplies<br>pulled the curtain, bu<br>placement. The nurs<br>30 ml distilled water<br>Tylenol, flushed with<br>water, administered  | on revealed the nurse placed<br>s, washed her hands, and<br>ut failed to check tube<br>se then flushed the tube with<br>before meds, administered<br>10 milliliters (ml) of distilled<br>Baclofen, flushed with 10 ml<br>Oxycodone, and then flushed<br>of water. |                     | · · ·   |                                       |                          |
| -                        | staff to use water flui   | plan initiated 4/19/18 directed<br>shes via PEG tube per MD<br>MD for increased flushes with  |                     | · · · · · · · · · · · · · · · · · · ·   | · · · · · · · · · · · · · · · · · · · | · · ·                    |

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|                          |   | AND HUMAN SERVICES  |                          |   | · FC            | ED: 01/09/201<br>RM APPROVEI<br>NO. 0938-039 |
|--------------------------|---|---|--------------------------|---|-----------------|--|
|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION G  | (X3)            | DATE SURVEY                                  |
|                          |   | 165453  | B, WING                  |   |                 | 12/03/2018                                   |
| NAME OF                  | PROVIDER OR SUPPLIER  |   | <u> </u>                 | STREET ADDRESS, CITY, STATE,  | ZIP CODE        |  |
| PEARL \                  | ALLEY REHABILITA  | TION & HEALTHCARE CENTER (  | ורר                      | 601 E POLK ST<br>WASHINGTON, IA 52353                                       |                 |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN O<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEF(CIEN | CTION SHOULD BE | (X5)<br>COMPLETION<br>DATE                   |
| F 658                    | Continued From pa   | -   | F 65                     | 8   |                 |  |
| :                        | signs of dehydratio   | <b>n.</b> .   |                          |   |                 | -  |
|                          | (MAR) and Physici   | ication Administration Record<br>an Order Summary for the<br>r revealed no orders to crush  |                          |   |                 |  |
|                          | 11/27/18 at 3 PM, s<br>to follow facility poli<br>order specified son   | the nurse consultant on<br>she stated shed expected staff<br>icy on flushing unless a doctor<br>nething different, and also<br>follow policy on checking<br>administration.   |                          |   |                 |  |
|                          | acknowledged not placement prior to a   | 1/27/18 at 16:45 PM , Staff A<br>checking the G tube for<br>administering of medications<br>were crushed but no Dr order.   |                          |   | . ·             |  |
|                          | medications per fee<br>check for appropria<br>15 ml water or accor<br>make sure is tube p<br>than one medicatio<br>one at a time and fl<br>between medication<br>30-50 ml of water of | policy for administering<br>eding tube instructed staff to<br>ate placement and flush with<br>ording to physician's orders to<br>batent. If administering more<br>in that requires crushing, give<br>lush with at least 5 ml water<br>in. Flush the tube again with<br>or the ordered amount to clear<br>ase potential for tube |                          |   |                 |  |
|                          | blockage.<br>2. The MDS dated<br>Resident #22 that in<br>incontinence, and of<br>MDS stated the res<br>assistance of 1 stat<br>dressing, toilet use,<br>extensive assistance          | 10/3/18, listed diagnoses for   |                          |   | •               |  |

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| ND PLAN C                | F CORRECTION  | IDENTIFICATION NUMBER:  |                     | n (f. 1997) an thu ann an fe                               |   | OMPLETED                 |
|--------------------------|---|---|---------------------|--|---|--------------------------|
|                          |   | 165453  | B. WING             |  | 1;  | 2/03/2018                |
|                          | PROVIDER OR SUPPLIER  | TION & HEALTHCARE CENTER C  | 60                  | REET ADDRESS, CITY, S<br>D1 E POLK ST<br>ASHINGTON, IA 523 | TATE, ZIP CODE  | <b>***</b> *             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | id<br>Prefix<br>Tag | (EACH CORRECT<br>CROSS-REFERENC                            | LAN OF CORRECTION<br>IVE ACTION SHOULD BE<br>ED TO THE APPROPRIATE<br>FICIENCY) | (X5)<br>COMPLETK<br>DATE |
| F 658                    | Continued From p<br>Interview for Ment<br>indicating intact co  | al Status) score as 14 out of 15,   | F 658               |  |   |                          |
|                          | Staff B CMA (Cert<br>the resident's roor<br>(Licensed Practica<br>stated it was the ro<br>narcotic pain med | ition on 11/28/18 at 8:45 a.m.,<br>ified Medication Aide) entered<br>n and handed Staff A LPN<br>al Nurse) a medication cup and<br>esident's hydrocodone (a<br>ication). Staff B left the room<br>quently administered the<br>resident. |                     | · .  |   |                          |
|                          | Record) listed an of<br>hydrocodone-acet<br>(milligrams) 1 tab<br>MAR, requested b<br>by the facility on 1  | AR (Medication Administration<br>order for<br>aminophen 5-325 mg<br>every 4 hours as needed. The<br>y the survey team and printed<br>1/29/18, did not reflect staff<br>hydrocodone on 11/28/18 at                                       |                     |  |   |                          |
|                          |   | y policy directed staff to read<br>el 3 times and identify the<br>Iministration.  |                     |  |   |                          |
| F 661<br>SS=D            | DON(Director of N<br>not give medication  | ry .  | F 661               | ·  |   |                          |
|                          | §483.21(c)(2) Disc<br>When the facility a<br>must have a dischabut is not limited to                        | harge Summary<br>nticipates discharge, a resident<br>arge summary that includes,  |                     |  |   |                          |

Facility ID: IA0948

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If continuation sheet Page 16 of 40

| CENTERS FOR MEDICARE & MEDICARD SERVICES         OMB NO.0383-0391           AND FLAN OF CORRECTION         (X) PROVIDENCY PREPRICUAL<br>IDENTIFICATION NUMBER:         (X) MULTIFIE CONSTRUCTION<br>A BUILDING         (X) MULTIFIE<br>(X) MULTIFIE CONSTRUCTION<br>(X) A BUILDING MULTIFIE CONSTRUCTION<br>(X) A FORMER ADDIE NOT THE SOUTH A BUILDING MULTIFIE CONSTRUCTION<br>(X) A FORMER ADDIE NOT THE SOUTH A BUILDING MULTIFIE<br>(X) MULTIFIE CONSTRUCTION A MULTIFIE CONSTRUCTION<br>(X) A FORMER ADDIE NOT THE SOUTH A BUILDING MULTIFIE CONSTRUCTION<br>(X) A FORMER ADDIE NOT THE SOUTH A BUILDING MULTIFIE CONSTRUCTION<br>(X) A FORMER ADDIE NOT THE SOUTH A BUILDING MULTIFIE CONSTRUCTION<br>(X) A FORMER ADDIE NOT THE SOUTH A BUILDING MULTIFIE CONSTRUCTION<br>(X) A FORMER ADDIE NOT THE SOUTH A BUILDING MULTIFIE CONSTRUCTION<br>(X) A FORMER ADDIE NOT THE SOUTH A BUILDING ADDIE NOT THE SOUTH A BUILDING ADDIE NOT THE SOUTH<br>(X  |           |  | AND HUMAN SERVICES  |         |     |   |               | FORM     | 01/09/2019<br>APPROVED | ) |
|--|-----------|--|---|---------|-----|---|---------------|----------|------------------------|---|
| NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, GTY, STATE, ZIP CODE<br>Of E POLK ST<br>WASHINGTON, IA 52353       (20) D<br>PREFIX<br>TAG     SUMMARY STATEMENT OF DEPICENCES<br>RESULATORY OR LSC DENTIFYING INFORMATION     BY<br>PREFIX<br>RESULATORY OR LSC DENTIFYING INFORMATION     PREFIX<br>FAG     PROVDERS FLAN OF CORRECTION<br>RECOURSE FLAN OF CORRECTION<br>REC | STATEMENT | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA   |         |     |   |               | (X3) DAT | E SURVEY               |   |
| PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O     641 E POLK ST<br>WASHINGTON, IA 52353       O(4) ID<br>PREPAR<br>TAG     SUMMARY STATEMENY OF DEFICIENCIES<br>(LACH DEFICIENCY MUST BE PRECEDED BY FULL<br>TAG     ID<br>PREPAR<br>(EACH CORRECTIVE AND OF CORRECTION<br>(EACH CORRECTIVE AND OF CORRECTIVE AND OF CORRECTIVE<br>AND INCIDENT, INCIDENT AND AND AND AND AND<br>CONSERVEMENT AND AND AND AND AND AND AND AND AND<br>(III) A final summary of the resident of the status to<br>includes, but is not limited to, diagnoses, course<br>of liness/treatment or therapy, and perifient lab,<br>radiology, and consultation results.<br>(III) A final summary of the resident's status to<br>include litems in paragraph (b)(1) of \$483.20, at<br>the time of the discharge that is available for<br>release to authorized persons and agencies, with<br>the consent of the resident or resident's<br>representative.<br>(III) Reconciliation of all pre-discharge<br>medications with the resident or resident<br>and, with the resident or the sident<br>and, with the resident or the sident<br>and, with the resident or the sident<br>and participation of the resident<br>over-the-counter).<br>(IV) A post-discharge that is<br>developed with the participation of the resident<br>and with the resident and and<br>nom-medical services.<br>This REQUIREMENT is not met as evidenced<br>by:<br>Based on record review and staff interview, the<br>facility failed to complete a recapituation of<br>Resident # 41 and 42 s stay at the facility in when<br>discharged. The facility reported a census of 37<br>residents.     Findings include:<br>The 90 day Minimum Data Set (MDS) dated<br>D9/12/18 documented Resident #42 bMINS (Brief<br>Interview of Mental Status score as 3 of 15, which<br>indicated Resident #42 demonstrated severe   |           |  | 165453  | B. WING | ·   | -                                       |               | 12/      | 03/2018                |   |
| PEARL VALLEY REHABILITATION & HEALTHCARE CENTER 0     WASHINGTON, IA 52353       (%1) D<br>PREETX<br>TAG     SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MART BE REACEBED BY FULL<br>(EACH DEFICIENCY AND THE REACEBED BY THE ACCEMPTER<br>(II) RECOUNTER) THE ADDED AND THE REACEBED BY THE ADDITION<br>(IV) A POST-DEFICIENCY AND THE REACEBED BY THE ADDITION OF<br>(II) REACEBED BY AND THE ADDITION OF ANY AND THE ADDITION OF<br>(II) REACEBED BY AND THE ADITION OF<br>(II) REACEBED BY AND THE ADITION OF<br>(II) REACEBED BY AND THE ADITION OF<br>(III) REACEBED BY AND THE ADITION OF<br>(III) REACEBED BY AND THE ADITION OF<br>(III) REACEBED BY AND THE ADITION OF<br>(IIII) REACEBED BY AND THE ADITION OF<br>(IIII) REACEBED BY AN  | NAME OF I | PROVIDER OR SUPPLIER   | · ·   |         |     |   | E, ZIP CODE   |          |                        | ] |
| Preferx<br>YAG       REGULATORY OR LSD DENTIFYING INFORMATION)       PREFX<br>TAG       IteAch concentry and should be information       Construct Action Should be information       Construct Action Should be information         F 681       Continued From page 16<br>includes, but is not limited to, diagnoses, course<br>of lines/treatment or therapy, and perflement lab,<br>radiology, and consultation results.       F 661       F 661         (ii) A final summary of the resident's status to<br>include items in paragraph (b)(1) of \$483.20, at<br>the time of the discharge that is available for<br>release to authorized persons and agencies, with<br>the consent of the resident or resident's<br>representative.       F 661         (iii) A final summary of the resident solution of all pre-discharge<br>medications (both prescribed and<br>over-the-counter).       F 661         (iv) A post-discharge plan of care that is<br>developed with the participation of the resident<br>and, with the resident's cost-discharge<br>medications with the resident's follow up<br>care and any post-discharge medical and<br>non-medical services.       F 661         by:       Based on record review and staff interview, the<br>facility field to complete a receiptulation of<br>by:       F         Based on record review and staff interview, the<br>facility field to complete a receiptulation of<br>Resident 4.1 and 42's stay at the facility in when<br>discharged. The facility reported a census of 37<br>residents.       F         Findings include:       The 90 day Minimum Data Set (MDS) dated<br>D9/12/16 documented Resident #42's BMS (Brief<br>Interview of Mental Status score as 3.0 f 13, which<br>indicated Resident #42 demonstrated severe       F   | PEARL V   |  | ION & HEALTHCARE CENTER C   |         |     |   |               |          |                        |   |
| includes, but is not limited to, diagnoses, course<br>of illness/treatment or therapy, and pertinent lab,<br>radiology, and consultation results.<br>(ii) A final summary of the resident's status to<br>include items in paragraph (b)(1) of \$483.20, at<br>the time of the discharge that is available for<br>release to authorized persons and agencies, with<br>the consent of the resident or resident's<br>representative.<br>(iii) Reconcilation of all pre-discharge<br>medications (both prescribed and<br>over-the-counter).<br>(iv) A post-discharge plan of care that is<br>developed with the participation of the resident<br>and, with the resident sonsent, the resident<br>and, with the resident sonsent, the resident<br>and, with the resident sonsent, the resident<br>to adjust to his or her new living environment. The<br>post-discharge plan of care must indicate where<br>the individual plans to resident solary<br>that have been made for the resident to<br>adjust to his or her new living environment. The<br>post-discharge plan of care must indicate where<br>the individual plans to reside, any arrangements<br>that have been made for the resident sollow up<br>care and any post-discharge medical and<br>non-medical services.<br>This REQUIREMENT is not met as evidenced<br>by:<br>Based on record review and staff interview, the<br>facility failed to complete a recapitulation of<br>Resident # 41 and 42's stay at the facility in when<br>discharged. The facility reported a census of 37<br>residents.<br>Findings include:<br>The 90 day Minimum Data Set (MDS) dated<br>09/12/18 documented Resident #42's BIMS (Brief<br>Interview of Mental Status score as 3 of 15, which<br>indicated Resident # 42 demonstrated severe  | PREFIX    | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL  | PREFI   |     | (EACH CORRECTIVE)<br>CROSS-REFERENCED 1 | ACTION SHOULD |          |                        |   |
| indicated Resident # 42 demonstrated severe  | F 661     | includes, but is not<br>of illness/treatment<br>radiology, and cons<br>(II) A final summary<br>include Items in part<br>the time of the disclerelease to authorize<br>the consent of the medications of<br>medications with the<br>medications (both pover-the-counter).<br>(iv) A post-discharge<br>developed with the<br>and, with the reside<br>representative(s), we<br>adjust to his or her in<br>post-discharge plans<br>that have been mad<br>care and any post-discharge plans<br>that have been mad<br>care and any p | imited to, diagnoses, course<br>or therapy, and pertinent lab,<br>ultation results.<br>of the resident's status to<br>agraph (b)(1) of §483.20, at<br>harge that is available for<br>be persons and agencies, with<br>esident or resident's<br>f all pre-discharge<br>e resident's post-discharge<br>rescribed and<br>e plan of care that is<br>participation of the resident<br>nt's consent, the resident<br>thich will assist the resident to<br>new living environment. The<br>of care must indicate where<br>to reside, any arrangements<br>le for the resident's follow up<br>lischarge medical and<br>es.<br>IT is not met as evidenced<br>wiew and staff interview, the<br>plete a recapitulation of<br>t2's stay at the facility in when<br>cility reported a census of 37 | F 6     | 561 |   |               |          |                        |   |
| CRM CMS-2567(02-99) Previous Versions Obsolete Event ID: CCO211 Facility ID: IA0948 If continuation sheet Page 17 of 40  | · ·       | Indicated Resident #   | # 42 demonstrated severe  |         |     |   |               |          |                        |   |

| AND PLAN C               | FCORRECTION  | IDENTIFICATION NUMBER:  |                     | NG   |                                       | PLETED                     |
|--------------------------|--|---|---------------------|--|---------------------------------------|----------------------------|
|                          |  | 165453  | B. WING             | 144, p. 4, p.                        | 121                                   | 03/2018                    |
|                          | PROVIDER OR SUPPLIER   | TION & HEALTHCARE CENTER  | 0                   | STREET ADDRESS, CITY, STATE<br>601 E POLK ST<br>WASHINGTON, IA 52353     | · · · · · · · · · · · · · · · · · · · |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN (<br>(EACH CORRECTIVE A<br>CROSS-REFERENCED T<br>DEFICIE | CTION SHOULD BE<br>O THE APPROPRIATE  | (X5)<br>COMPLETION<br>DATE |
| F 661                    | included asthma, m<br>restless leg syndro<br>weakness, rheuma<br>breath.<br>The plan of care fa<br>planning informatio<br>staff directive to he<br>discharge.<br>The nursing progre<br>09/14/18 failed to p<br>regarding the resid<br>belongings returned<br>discharge instructio<br>information.<br>A review of the resi<br>provide any indicati<br>recapitulation of the<br>A policy for Resider<br>dated 11/28/2016 d<br>transfer/discharge i<br>resident's medical r<br>information commu<br>facility. The policy a<br>should include all in | age 17<br>In memory issues. Diagnoses<br>espiratory failure, dysphasia,<br>me, heart disease, muscle<br>itoid arthritis, and shortness of<br>illed to contain any discharge<br>on for Resident # 42 except a<br>lip obtain support services at<br>ess discharge notes dated<br>provide any information<br>ent's personal items and the<br>d, return of medications,<br>ons/teaching, or referral<br>dent's medical record failed to<br>on facility staff completed a<br>e resident's stay as required.<br>In Transfer and Discharge<br>lirected staff to ensure the<br>information documented in the<br>record and the appropriate<br>uncated to the receiving<br>also directed the information<br>aformation necessary for<br>care and a discharge | F 6                 | 61   |                                       |                            |
|                          | 11/07/17 directed si<br>and physical, Physic<br>Physician, follow-up<br>provide the resident<br>medications, instruct  | Discharges to Home, dated<br>taff to fax medications, history<br>cians visits to current<br>o instructions given, and<br>t with a current list of<br>ctions, follow-up<br>any cares needed or referrals.  |                     | · .  | •                                     |                            |
| ORM CMS-25               | 37(02-99) Previous Versions  | Obsolete Event ID: CCO2   | 11 .                | Facility ID; IA0948  | If continuation sheet I               | Page 18 of 40              |

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|                          | · ·   | & MEDICAID SERVICES  |                     |   | O               | FORM API<br>MB NO. 09  |                          |
|--------------------------|---|--|---------------------|---|-----------------|------------------------|--------------------------|
| STATEMENT                | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | LE CONSTRUCTION   |                 | (X3) DATE SU<br>COMPLE | RVEY                     |
|                          |   | 165453   | B. WING             |   |                 | 12/03/2                | 2018                     |
|                          | PROVIDER OR SUPPLIER  | ION & HEALTHCARE CENTER C  | 6                   | STREET ADDRESS, CITY, STAT<br>601'E POLK ST<br>VASHINGTON, 1A 52353 |                 |                        |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN<br>(EACH CORRECTIVE<br>CROSS-REFERENCED<br>DEFIC    | ACTION SHOULD   | BE CO                  | (X5)<br>MPLETION<br>DATE |
| F 661                    | Continued From pa   | ge 18 .  | F 661               |   |                 |                        |                          |
|                          | BIMS score of 15 (t<br>memory intact) for I<br>included hypo-osmo<br>hypothyroidism, GE       | /IDS date 09/26/18 revealed a<br>both long and short term<br>Resident # 41. Diagnoses<br>blality, hyponatremia,<br>RD, major depression,<br>ness, and difficulty walking.                                |                     |   |                 |                        |                          |
|                          |   | h an initiation date of<br>ave any plan or interventions<br>ing.   |                     |   |                 |                        |                          |
|                          | A discharge plannin<br>P.M., noted the resi<br>personal belongings                            | g note on 11/7/2018 at 1:20<br>dent's daughter picked up his<br>s on 11/2./18.   |                     |   |                 |                        |                          |
|                          | 10/30/2018 4:02 P.I<br>the hospital with ind<br>The County Clerk                              | ent's record revealed on.<br>M., Resident # 41 admitted to<br>reased psychiatric behaviors.<br>changed the resident's court<br>spital. Resident #41's<br>transfer.                                       |                     |   |                 |                        |                          |
|                          | transfer instructions   | complete any discharge or<br>/information, recapitulation of<br>distribution at the end of the<br>e facility.  | -                   |   | ,               |                        |                          |
|                          | verified no recapitul<br>reported the resider<br>to another facility af<br>added Resident # 4 | AM, the facility Administrator<br>ation of stay completed and<br>it had been court committed<br>ter the hospitalization. She<br>1 sent to the hospital for an<br>reased psychiatric behaviors<br>m there |                     |   |                 |                        |                          |
| F 679<br>SS=D            |   | est/Needs Each Resident  | F 679               |   |                 |                        |                          |
| FORM CMS-25              | 67(02-99) Previous Versions   | Obsolete Event ID: CCO21   | 1 Fa                | cility ID: IA0948   | If continuation | on sheet Page          | 19 of 40                 |

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PRINTED: 01/09/2019

| AND PLAN C               | FCORRECTION   | IDENTIFICATION NUMBER:  |                     |   | COMPLETED     |
|--------------------------|---|---|---------------------|---|---------------|
|                          |   | 165453  | B. WING             |   | 12/03/2018    |
|                          | PROVIDER OR SUPPLIER  | TION & HEALTHCARE CENTER C  | ) 6                 | BTREET ADDRESS, CITY, STATE, ZIP CODE<br>601 E POLK ST<br>VASHINGTON, IA 52353                                  | ; IA:00:20 IO |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMPLETION |
| F 679                    | the comprehensive<br>and the preference<br>program to support<br>activities, both facil<br>individual activities<br>designed to meet th<br>physical, mental, ar<br>each resident, enco<br>and interaction in th<br>This REQUIREMEN<br>by:<br>Based on observat<br>staff interview, the f<br>document the invol-<br>residents reviewed<br>reported a census of<br>the survey.<br>Findings include:<br>1. The Minimum D<br>8-11-2018 document<br>hypertension, pneu-<br>non-traumatic intrace<br>unspecified and dys<br>mental status was r<br>totally dependent, re-<br>including bed mobili-<br>toileting, personal h<br>assessment (CAA)<br>psychosocial well be<br>An observation on 1<br>Resident #1 in bed<br>place. Observation<br>1/27/18 reflected n | s.<br>facility must provide, based on<br>assessment and care plan<br>s of each resident, an ongoing<br>residents in their choice of<br>ity-sponsored group and<br>and independent activities,<br>ne interests of and support the<br>nd psychosocial well-being of<br>ouraging both independence<br>ne community.<br>NT is not met as evidenced<br>tion, clinical record review and<br>acility failed to provide and<br>vement of activities for 1 of 12<br>(Resident #1). The facility<br>of 37 residents at the time of<br>ata Set (MDS) dated<br>need diagnoses of Hemiplegia,<br>monia, aphasia, stroke,<br>cerebral hemorrhage,<br>sphasia. A brief interview for<br>not assessed. Resident is<br>equiring 2 assist for all cares<br>ity, transfers, dressing,<br>ygiene. The care area | F 679               |   |               |

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Facility ID: IA0948

If continuation sheet Page 20 of 40

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| DEPARTMENT OF HEALTH AND HUMAN SERVICE  | CES |
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| CENTERS FOR MEDICARE & MEDICAID SERVICE | CES |

PRINTED: 01/09/2019 FORM APPROVED

| CENTE                    | RS FOR MEDICARE  | E & MEDICAID SERVICES  |                   |            | <u>(</u>   | <u>NVIR NO</u> | 0938-0391                  |
|--------------------------|--|--|-------------------|------------|--|----------------|----------------------------|
| STATEMEN                 | T OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |            | E CONSTRUCTION   |                | e survey<br>Pleted         |
|                          |  | 165453   | B. WING           | )          | ······································   | 12/            | 03/2018                    |
| NAME OF                  | PROVIDER OR SUPPLIER   |  | <b>.</b>          |            | TREET ADDRESS, CITY, STATE, ZIP CODE   |                | •                          |
| PEARL                    | ALLEY REHABILITA   | TION & HEALTHCARE CENTER C   | )                 |            | 01 E POLK ST<br>VASHINGTON, IA 52353   |                |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |            | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | DBE ·          | (X5)<br>COMPLETION<br>DATE |
| F 679<br>F 685<br>SS=D   | 09:04 AM, she veri<br>on any activities or<br>with Resident #1. T<br>former activity direct<br>resident by reading<br>no documentation of<br>facility. The Admini-<br>activity director star<br>weeks ago and pla-<br>activity or activity lo<br>Treatment/Devices                             | area.<br>the Administrator on 11/28/18<br>fied the lack of documentation<br>any staff of activity staff 1:1<br>the Administrator reported the<br>otor had engaged with the<br>to him or providing music, but<br>of that was provided by the<br>strator reported the new<br>rted working at the facility 3<br>nned to address the lack of<br>og for the resident.<br>to Maintain Hearing/Vision |                   | 679<br>685 |  |                |                            |
|                          | and assistive devic<br>hearing abilities, the<br>assist the resident-<br>§483.25(a)(1) In ma<br>§483.25(a)(2) By an<br>and from the office<br>the treatment of vis<br>the office of a profe<br>provision of vision of<br>This REQUIREMEN<br>by:<br>Based on observat<br>review, the facility f | dents receive proper treatment<br>es to maintain vision and<br>e facility must, if necessary,  |                   | -          |  |                |                            |
|                          | treatment and assis  | stive devices to maintain their<br>9). The facility reported a   |                   |            | · · · · · · · · · · · · · · · · · · ·  |                |                            |
|                          | •  |  | ,                 |            |  |                |                            |

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

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Facility ID: IA0948

If continuation sheet Page 21 of 40

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| d plan o                              | FCORRECTION   | IDENTIFICATION NUMBER:  | A. BUILDING         |  |         | PLETED                     |
|---------------------------------------|---|---|---------------------|--|---------|----------------------------|
|                                       | 4   | 165453  | B, WING             |  |         | 03/2018                    |
|                                       | ROVIDER OR SUPPLIER   | ION & HEALTHCARE CENTER   | 0 G                 | NTREET ADDRESS, CITY, STATE, ZIP CODI<br>101 E POLK ST<br>VASHINGTON, IA 52353                       | Ξ       |                            |
| (X4) ID<br>PREFIX<br>TAG              | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |
| F 685                                 | Continued From pa<br>Findings include:  | ge 21   | F 685               |  |         |                            |
| · · · · · · · · · · · · · · · · · · · | tool, dated 10/5/18,<br>#19 included repeat<br>weakness. The MI<br>supervision assista<br>walking, toilet use,<br>supervision and set<br>and eating, and ext<br>bathing. The MDS<br>(Brief Interview for<br>15, which indicated<br>listed the resident's<br>documented the resi<br>lenses.<br>The MDS dated 12/ | num Data Set) assessment<br>listed diagnoses for Resident<br>ted falls, chronic pain, and<br>DS stated the resident required<br>nce for bed mobility, transfers<br>and personal hygiene,<br>t up assistance for dressing<br>ensive assistance of 1 staff fo<br>listed the resident's BIMS<br>Mental Status) score as 13 of<br>intact cognition. The MDS<br>vision as adequate and<br>sident did not wear corrective | 1<br>r              |  |         |                            |
|                                       | lenses.<br>During an observat<br>the resident walked<br>toward the dining ro<br>to the surveyor and   | ate vision and wore corrective<br>ion on 11/27/18 at 8:12 a.m.,<br>with a walker in the hallway<br>oom. The resident said hello<br>appear to be squinting. The<br>ne surveyor that she could not  |                     |  | •       |                            |
|                                       | had an evaluation fit time period of 9/14/  | locumentation the resident<br>rom an eye doctor during the<br>17 and the survey week<br>surveyor brought the matter<br>he Administrator.  |                     |  |         |                            |
| -                                     | resident had impain<br>not show a decline<br>review date. The ca  | nitiated 5/12/16, revealed the<br>ed visual function and would<br>in visual function through the<br>are plan directed staff to assis<br>appointments as needed and  |                     | <b>* 3</b>   |         |                            |

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| TATEMENT                 | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION  | (X3) DAT | ). 0938-039<br>FE SURVEY<br>MPLETED |
|--------------------------|---|---|---------------------|---|----------|-------------------------------------|
|                          |   | 165453  | B. WING             |   | 12       | /03/2018                            |
|                          | PROVIDER OR SUPPLIER  | NON & HEALTHCARE CENTER   | , <sup>6</sup>      | TREET ADDRESS, CITY, STATE, ZIP CODE<br>01 E POLK ST<br>VASHINGTON, IA 52353                          |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | ould be  | (X5)<br>COMPLETION<br>DATE          |
| F. 685                   | ensure appropriate  | ge 22<br>visual aldes/glasses were<br>t the resident's participation in   | F 685               | •<br>•<br>•   |          |                                     |
|                          | resident stated she   | on 11/27/18 at 8:39 a.m., the<br>could not see. She stated<br>it they were "no good".   |                     |   | ,        |                                     |
| F 686<br>SS=D            | DON (Director of N<br>would develop a me<br>assessing vision. S<br>ask residents if the   | on 11/29/18 at 9:17 a.m., the<br>ursing) stated the facility<br>ore formal method for<br>She stated the facility should<br>y had any visual concerns.<br>Prevent/Heal Pressure Ulcer<br>1)(i)(ii)   | F 686               |   |          | •                                   |
|                          | resident, the facility<br>(i) A resident receiv<br>professional standa<br>pressure ulcers and<br>ulcers unless the in<br>demonstrates that t<br>(ii) A resident with p<br>necessary treatmen<br>with professional st<br>promote healing, pr | sure ulcers.<br>rehensive assessment of a<br>must ensure that-<br>es care, consistent with<br>urds of practice, to prevent<br>does not develop pressure<br>dividual's clinical condition<br>hey were unavoidable; and<br>pressure ulcers receives<br>and services, consistent<br>andards of practice, to<br>event infection and prevent |                     |   |          |                                     |
|                          | by:<br>Based on observat<br>interview, the facilit<br>carry out intervention<br>for 1 of 1 residents  | veloping.<br>NT is not met as evidenced<br>ion, record review, and<br>y failed to properly assess and<br>ons to prevent a pressure ulcer<br>reviewed with a current open<br>eported a census of 37  |                     | -   | •        |                                     |

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| AND PLAN O               | FCORRECTION   | IDENTIFICATION NUMBER:  |                     | <u></u>   | COMPLETED |                            |
|--------------------------|---|---|---------------------|---|-----------|----------------------------|
|                          |   | 165453  | B, WING             |   | 12/       | 03/2018                    |
|                          | PROVIDER OR SUPPLIER  | ION & HEALTHCARE CENTER C   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>601 E POLK ST<br>WASHINGTON, IA 52353                                  | ·         |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | id<br>Prefix<br>Tag | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>Completion<br>Date |
| F 686                    | Continued From pa   | ge 23   | F 686               | 3   |           |                            |
|                          | #22 had diagnoses<br>difficulty walking, ar<br>The MDS documen<br>limited assist of 1 s<br>assist of 1 staff for<br>toilet use, and persi-<br>documented Reside<br>assistance of 2 staf<br>totally dependent of<br>identified the reside<br>Mental Status) scor | MDS dated 10/3/18, Resident<br>that included diabetes,<br>ad chronic kidney disease.<br>ted the resident required<br>taff for eating and extensive<br>transfers, walking, dressing,<br>onal hygiene. The MDS also<br>ent #22 required extensive<br>f for bed mobility, and was<br>an 1 staff for bathing. The MDS<br>int's BIMS (Brief Interview for<br>e as 14 of 15, indicating intact<br>mented the resident was at<br>ressure ulcers. |                     |   |           |                            |
|                          | the surveyor walked<br>breakfast table and<br>surveyor she had so<br>and was in pain. The<br>room chair and had<br>During an observation<br>the resident sat in a<br>her in the activity room   | on on 11/27/18 at 8:22 a.m.,<br>chair without a cushion under<br>om. Subsequent<br>ed the resident in the activity  |                     |   |           |                            |
|                          | During an observati<br>Staff C CNA (Certifi<br>the room as the res<br>resident told Staff C<br>resident stood up ar<br>sized red area on th<br>appeared to be miss  | on on 11/27/18 at 10:03 a.m.,<br>ed Nursing Assistant) entered<br>ident sat in a recliner. The<br>her bottom hurt. The<br>nd had an approximate dime<br>e right buttock which<br>sing layers of skin. The area<br>white flakes and the resident's   |                     |   |           |                            |

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Facility ID: 1A0948

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If continuation sheet Page 24 of 40

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

# PRINTED: 01/09/2019 FORM APPROVED

| CENTE                    | RS FOR MEDICARE  | E & MEDICAID SERVICES  |                     |          | (   | <u> MB NO</u> | <u>. 0938-0391</u>         |
|--------------------------|--|--|---------------------|----------|---|---------------|----------------------------|
| ,                        | OF DEFICIENCIES<br>OF CORRECTION   | (X1). PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |          | E CONSTRUCTION  |               | TE SURVEY<br>APLETED       |
|                          | . `  | 165453   | B. WING             |          |   | 12/           | 03/2018                    |
| NAME OF I                | PROVIDER OR SUPPLIER   | ·····  |                     | \$       | TREET ADDRESS, CITY, STATE, ZIP CODE  |               |                            |
|                          |  |  |                     | 6        | 01 E POLK ST  |               |                            |
| PEARL                    |  | NON & HEALTHCARE CENTER C  | >                   |          | ASHINGTON, IA 52353   |               | •                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | id<br>Prefi)<br>Tag | <b>X</b> | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) 8E          | (X5)<br>COMPLETION<br>DATE |
| F 686                    | entire right buttock<br>Staff C mixed A and<br>(ointments used to<br>applied this to the a<br>back down in the re-<br>would tell the nurse<br>an order for someth<br>treatment). The re-<br>bad she could not s<br>resident's recliner v<br>incontinence pad and<br>cushion present. F<br>stated to the survey<br>how long the reside<br>was approximately<br>During an observati<br>the resident sat in a<br>no cushion under h | was reddish purplish in color.<br>d D Ointment and Peri Guard<br>treat skin irritation) and<br>urea, then the resident sat<br>ecliner. Staff A stated she<br>and they would try to obtain<br>hing additional (skin<br>sident stated the area hurt so<br>sleep the previous night. The<br>was covered with a cloth<br>and did not appear to have a<br>ollowing the cares, Staff C<br>yor she was not exactly sure<br>and had the area but thought is<br>1 week.<br>ion on 11/27/18 at 12:30 p.m.,<br>a chair at the lunch table with<br>er. | F 6                 | 86       |   |               |                            |
|                          | the resident sat in h<br>not appear to have<br>During an observati<br>Staff D CNA assiste<br>from her recliner as<br>Practical Nurse) me<br>the resident's right I<br>cm(centimeter) x 1.<br>measuring 0.5 cm.<br>resident had somet<br>(11/26/18) when she<br>not open at that tim<br>area, the resident s<br>had a visible, thick I<br>stated the black cus<br>cushion used to pre   | er recliner. The recliner did  | -<br>-              |          |   |               |                            |

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

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Facility (D: IA0948

If continuation sheet Page 25 of 40

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| ID PLAN O                | FCORRECTION   | IDENTIFICATION NUMBER:  | A. BUILDI           | NG  | .   | COMPLETE     | D                    |
|--------------------------|---|---|---------------------|---|---|--------------|----------------------|
|                          |   | 165453  | B. WING _           | ······  | _   | 12/03/20     | 18                   |
|                          | ROVIDER OR SUPPLIE  | R<br>ATION & HEALTHCARE CENTER (  |                     | STREET ADDRESS, CITY, STA<br>601 E POLK ST<br>WASHINGTON, IA 5235 |   |              |                      |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>& LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CORRECTIV<br>CROSS-REFERENCE                                | N OF CORRECTION<br>E ACTION SHOULD BE<br>D TO THE APPROPRIAT<br>CIENCY) | COMP         | X6)<br>PLETIC<br>ATE |
| F 686                    | Continued From  |   | F 68                |   |   |              |                      |
|                          | as she pointed to   | the counter. On the counter<br>ximately 1 cm thick) yellow gel  |                     |   | ·   |              |                      |
|                          | resident had an or approximately 1 of   | m. progress note stated the<br>pen area on the right buttocks<br>om round, superficial and the<br>discomfort when sitting.  |                     |   |   |              |                      |
|                          | order for an Optif  | m., a progress note listed an<br>oam border dressing (a foam<br>ght buttocks applied every other<br>ed.   |                     |   |   |              |                      |
|                          | to discontinue the<br>begin Calmosepti<br>cushion in the cha<br>any documentation | m. progress note listed an order<br>optifoam border dressing and<br>ne ointment and utilize a Roho<br>air. The progress note lacked<br>on of an assessment of the<br>state the area was healed. |                     |   |   |              |                      |
|                          | had a question m<br>lacerations, lesion<br>location was to th                     | ned "Weekly Skin Assessment"<br>arked "yes" for "open cuts,<br>hs, or skin tears" and stated the<br>e right buttocks and the facility<br>reatment on 10/8/18.                                   |                     |   |   | . ,          |                      |
|                          | resident reported   | 2 a.m. progress note stated the<br>pain in the bottom and the<br>hysician regarding an order for<br>ing.  |                     |   |   |              |                      |
|                          |   | any further assessments of the dates of 9/21/18 and 11/28/18 e survey week).  |                     |   |   |              |                      |
|                          | Administration Re   | ober TAR (Treatment<br>cord) revealed the resident<br>ptine ointment to the buttocks  |                     |   | y<br>   |              |                      |
| A CMS-258                | 7(02-99) Previous Version   | ns Obsolete Event ID: CCO21   | 1 F                 | acility ID; IAD948  | If continuation sl  | neet Page 24 | 6 0                  |
|                          |   | <b>,</b>  |                     | N 199   |   |              |                      |
|                          | ,<br>,  | ·   |                     |   |   |              |                      |
| •                        |   | · · · · ·   |                     |   |   | <i>!</i>     |                      |

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| STATEMENT OF DEPENDENCES<br>AND PLAN OF CORRECTION         (X) PROVIDER/SUPPLIER/LINE<br>DENTIFICATION NUMBER<br>IDENTIFICATION NUMBER<br>(PARLIES)         02 MILTIFIC CONSTRUCTION<br>A PUILDING<br>(DENTIFICATION NUMBER)         02 MILTIFIC CONSTRUCTION<br>A PUILDING<br>(DENTIFICATION NUMBER)         02 MILTIFIC CONSTRUCTION<br>(DENTIFICATION NUMBER)         02 MILTIFIC CONSTRUCTION<br>(DENTIFICATION NUMBER)         02 MILTIFIC CONSTRUCTION<br>(DENTIFICATION NUMBER)         02 MILTIFICATION<br>(DENTIFICATION   |           |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |          |          |   |                               | FORM | 01/09/2019<br>APPROVED<br>0938-0391 |
|---|-----------|--|---|----------|----------|---|-------------------------------|------|-------------------------------------|
| MAKE OF PROVIDER OR SUPPLIER       SIMUMARY STREMENT OF DEFIDENCES       STREET ADDRESS, GITY, STATE, ZIP CODE         MAKE OF PROVIDER'S PLAN OF CORRECTION & HEALTHCARE CENTER O       BILL       Gamma Control of Definition Definition of Definition of Definition of Definition Definition Definition of Definition of Definition D   | STATEMENT | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA   | 1        |          |   |                               |      |                                     |
| PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O     B01 E POLK ST<br>WASHINGTON, IA 52353       PREFX<br>TAG     SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED UN FULL<br>TAG     PREFX<br>PREVATOR STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED UN FULL<br>TAG     PREFX<br>PREVATOR STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED UN FULL<br>TAG     PREFX<br>PREVATOR STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED UN FULL<br>TAG     PREFX<br>PREVATOR STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED UN FULL<br>TAG     PREFX<br>PREVATOR STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY OF LSE DUNTIFYING INFORMATION)     PREFX<br>TAG     PREFX<br>PREVATOR STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY OF LSE DUNTIFYING INFORMATION)     PREFX<br>TAG     PREFX<br>PREVATOR STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY OF LSE DUNTIFYING INFORMATION)     PREFX<br>TAG     PREFX<br>PREVATOR STATEMENT OF DEFICIENCIES<br>(FORMATION OF DEFICIENCIES<br>(FORMATION OF DEFICIENCIES)<br>(FORMATION OF DEFICI   | •         |  | 165453  | .B, WING | <u> </u> |   |                               | 12/  | 03/2018                             |
| PERAL VALLEY REHABILITATION & HEALTHCARE CENTER O       WASHINGTON, (A 52353         (%) JD<br>PRETX<br>TAG       SUMMARY STATEMENT OF DEFICIENCIES.<br>(EACH DEFICIENCY MARY BEREAGED UP FULL<br>RESULATORY OR LSC DENTFY/ING INFORMATION)       D<br>PROVIDERS FLAM OF CORRECTION<br>(EACH DEFICIENCY MARY BEREAGED UP FULL<br>RESULATORY OR LSC DENTFY/ING INFORMATION)       D<br>PROVIDERS FLAM OF CORRECTION<br>(EACH OF CORRECTIVE ACTION SINCE OWNER<br>(CROSS-REFERENCE ACTION)<br>(EACH OF CORRECTIVE ACTION SINCE OWNER<br>(CROSS-REFERENCE ACTION)<br>(EACH OF CORRECTIVE ACTION SINCE ACTION<br>(EACH OF CORRECTIVE ACTION SINCE ACTION<br>(EACH OF CORRECTIVE ACTION SINCE ACTION)<br>(EACH OF CORRECTIVE ACTION SINCE ACTION<br>(EACH OF CORRECTIVE ACTION SINCE ACTION<br>(EACH OF CORRECTIVE ACTION SINCE ACTION<br>(EACH OF CORRECTIVE ACTION SINCE ACTION)<br>(EACH OF CORRECTIVE ACTION SINCE ACTION<br>(EACH OF CORRECTIVE ACTION SINCE ACTION<br>(EACH OF CORRECTIVE ACTION SINCE ACTION<br>(EACH OF CORRECTIVE ACTION ACTION)<br>(EACH OF CORRECTIVE ACTION<br>(EACH OF CORRECTIVE ACTION<br>(EACH OF CORRECTIVE ACTION)<br>(EACH OF CORRECTIVE ACTION<br>(EACH OF CORRECTIVE ACTION<br>(EACH OF CORRECTIVE ACTION)<br>(EACH OF CORRECTIVE ACTION<br>(EACH OF CORRECTIVE ACTION<br>(EACH OF CORRECTIVE ACTION)<br>(EACH OF CORRECTIVE ACTION<br>(EACH OF CORRECTIVE ACTION<br>(EACH OF CORRECTIVE ACTION)<br>(EACH OF CORRECTIVE ACTION<br>(EACH | NAME OF I | PROVIDER OR SUPPLIER   |   | · .      | S        | TREET ADDRESS, CITY, STATE                | , ZIP CODE                    |      |                                     |
| Prescription         react before the precedence of PULL<br>Resolution of USE IDENTIFYING INFORMATION)         PRETX<br>TAG         CEACH CORRENCE ACTION SHOULD BE<br>CROSS-REFERENCE TO THE APPROPRIATE<br>DEFICENCY         Conduction of USE IDENTIFYING INFORMATION)           F 686         Continued From page 26<br>from 10/8/18-10/21/18.         F 686         F 686           Review of the October and November TARS<br>revealed the facility lacked documentation of a<br>skin treatment to the right buttocks from<br>10/21/18-11/28/18.         F 686           The facility lacked documentation of physician<br>notification of an open area from the period of<br>11/3/18 when facility charting documented an<br>open area and the survey week (11/26/18).         F           The Braden Scale for Predicting Pressure Score<br>Risk, dated 10/9/18, stated the resident was at<br>low risk for the development of pressure ulcers.         Care plan entries, revised 5/9/18, documented<br>the resident as it risk for impainment to skin<br>integrity related to scratching and immobility, and<br>stated the resident as diff to educate the resident<br>regarding measures to prevent skin trijury,<br>encourage good nutrition and hydration, and to<br>identify potential causative factors.           Care plan entries, initiated 8/2/17, instructed to<br>avoid scratching and keep hands and body parts<br>from excessive molsture, follow facility protocols<br>for the treatment of skin injury and report abnormalities<br>to the physician.         Each for the charin's to<br>prevent and treat skin breakdown and lacked<br>documentation the resident had a current open<br>area or a history of previous open areas.  | PEARL V   | ALLEY REHABILITAT  | ION & HEALTHCARE CENTER   | D        |          |   |                               |      |                                     |
| from 10/8/18-10/21/18.<br>Review of the October and November TARS<br>revealed the facility lacked documentation of a<br>skin treatment to the right buttocks from<br>10/21/18-11/28/18.<br>The facility lacked documentation of physician<br>notification of an open area from the period of<br>11/3/18 when facility charting documented an<br>open area and the survey week (11/26/18).<br>The Braden Scale for Predicting Pressure Sore<br>Risk, dated 10/9/18, stated the resident was at<br>low risk for the development of pressure ucers.<br>Care plan entries, revised 5/9/18, documented<br>the resident as at risk for impairment to skin<br>integrity related to scratching and immobility, and<br>stated the resident would maintain clean and<br>intact skin by the review date. Additional 5/9/18<br>entries directed staff to educate the resident<br>regarding measures to prevent skin injury,<br>encourage good nutrition and hydration, and to<br>identify potential causative factors.<br>Care plan entries, initiated 8/2/17, instructed to<br>avoid scratching and keep hands and body parts<br>from excessive moisture, follow facility protocols<br>for the treatment of Injury, keep skin clean and<br>dry, and monitor/document location, size, and<br>treatment of skin injury and report abnormalities<br>to the physician.<br>The care plan lacked further specific interventions<br>(including the Roho cushion for the chair) to<br>prevent and treat skin breakdown and lacked<br>documentation the resident to acument open<br>area or a history of previous open areas.   | PREFIX    | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL  | PREFI    |          | (EACH CORRECTIVE A<br>CROSS-REFERENCED TO | CTION SHOULD<br>O THE APPROPF | BE   | COMPLETION                          |
| <ul> <li>skin treatment to the right buttocks from 10/21/18-11/28/18.</li> <li>The facility lacked documentation of physician notification of an open area from the period of 11/3/18 when facility charting documented an open area and the survey week (11/26/18).</li> <li>The Braden Scale for Predicting Pressure Sore Risk, dated 10/9/18, stated the resident was at low risk for the development of pressure ulcers.</li> <li>Care plan entries, revised 5/9/18, documented the resident was at low risk for the development of pressure ulcers.</li> <li>Care plan entries, revised 5/9/18, documented the resident was at the resident was at the resident as at risk for impairment to skin integrity related to scratching and immobility, and stated the resident would maintain clean and intact skin by the review date. Additional 5/9/18 entries directed staff to educate the resident regarding measures to prevent skin injury, regording measures to prevent skin injury, encourage good nutrition and hydration, and to identify potential causative factors.</li> <li>Care plan entries, initiated 8/2/17, instructed to avoid scratching and keep hands and body parts from excessive moisture, follow facility protocols for the treatment of finury, keep skin clean and dry, and monitor/document location, size, and treatment of skin injury and report abnormalities to the physician.</li> <li>The care plan lacked further specific interventions (including the Roho cushion for the chair) to prevent and treat skin breakdown and lacked documentation the resident thad a current open areas.</li> </ul>  | F 686     | from 10/8/18-10/21/<br>Review of the Octob   | 18.<br>Der and November TARS  | F 6      | 86       |   |                               |      |                                     |
| <ul> <li>notification of an open area from the period of 11/3/18 when facility charting documented an open area and the survey week (11/26/18).</li> <li>The Braden Scale for Predicting Pressure Sore Risk, dated 10/9/18, stated the resident was at low risk for the development of pressure ulcers.</li> <li>Care plan entries, revised 5/9/18, documented the resident as at risk for impairment to skin integrity related to scratching and immobility, and stated the resident would maintain clean and intact skin by the review date. Additional 5/9/18 entries directed staff to educate the resident area insident to a survey weak (11/26/18).</li> <li>Care plan entries, revised 5/9/18, documented the resident as at risk for impairment to skin and intact skin by the review date. Additional 5/9/18 entries directed staff to educate the resident regarding measures to prevent skin injury, encourage good nutrition and hydration, and to identify potential causative factors.</li> <li>Care plan entries, initiated 8/2/17, instructed to avoid scratching and keep hands and body parts from excessive moisture, follow facility protocols for the treatment of injury, keep skin clean and dry, and monitor/document location, size, and treatment of skin injury and report abnormalities to the physician.</li> <li>The care plan lacked further specific interventions (including the Roho cushion for the chair) to prevent and treat skin breakdown and lacked documentation the resident had a current open area or a history of previous open areas.</li> </ul>  |           | skin treatment to the 10/21/18-11/28/18.   | e right buttocks from   |          |          |   |                               |      |                                     |
| Risk, dated 10/9/18, stated the resident was at<br>low risk for the development of pressure ulcers.         Care plan entries, revised 5/9/18, documented<br>the resident as at risk for impairment to skin<br>integrity related to scratching and immobility, and<br>stated the resident would maintain clean and<br>intact skin by the review date. Additional 5/9/18<br>entries directed staff to educate the resident<br>regarding measures to prevent skin injury,<br>encourage good nutrition and hydration, and to<br>identify potential causative factors.         Care plan entries, initiated 8/2/17, instructed to<br>avoid scratching and keep hands and body parts<br>from excessive moisture, follow facility protocols<br>for the treatment of injury, keep skin clean and<br>dry, and monitor/document location, size, and<br>treatment of skin injury and report abnormalities<br>to the physician.         The care plan lacked further specific interventions<br>(including the Roho cushion for the chair) to<br>prevent and treat skin breakdown and lacked<br>documentation the resident had a current open<br>area or a history of previous open areas.  |           | notification of an op<br>11/3/18 when facility   | en area from the period of<br>/ charting documented an  |          |          | · · · · ·                                 |                               |      |                                     |
| the resident as at risk for impairment to skin<br>integrity related to scratching and immobility, and<br>stated the resident would maintain clean and<br>intact skin by the review date. Additional 5/9/18<br>entries directed staff to educate the resident<br>regarding measures to prevent skin injury,<br>encourage good nutrition and hydration, and to<br>identify potential causative factors.<br>Care plan entries, initiated 8/2/17, instructed to<br>avoid scratching and keep hands and body parts<br>from excessive moisture, follow facility protocols<br>for the treatment of injury, keep skin clean and<br>dry, and monitor/document location, size, and<br>treatment of skin injury and report abnormalities<br>to the physician.<br>The care plan lacked further specific interventions<br>(including the Roho cushion for the chair) to<br>prevent and treat skin breakdown and lacked<br>documentation the resident had a current open<br>area or a history of previous open areas.   |           | Risk, dated 10/9/18,<br>low risk for the deve  | , stated the resident was at<br>elopment of pressure ulcers.  |          |          |   |                               |      | -                                   |
| encourage good nutrition and hydration, and to<br>identify potential causative factors.<br>Care plan entries, initiated 8/2/17, instructed to<br>avoid scratching and keep hands and body parts<br>from excessive moisture, follow facility protocols<br>for the treatment of injury, keep skin clean and<br>dry, and monitor/document location, size, and<br>treatment of skin injury and report abnormalities<br>to the physician.<br>The care plan lacked further specific interventions<br>(including the Roho cushion for the chair) to<br>prevent and treat skin breakdown and lacked<br>documentation the resident had a current open<br>area or a history of previous open areas.   |           | the resident as at ris<br>integrity related to s<br>stated the resident v<br>intact skin by the rev<br>entries directed staf | sk for impairment to skin<br>cratching and immobility, and<br>would maintain clean and<br>view date. Additional 5/9/18<br>f to educate the resident |          |          |   |                               |      |                                     |
| avoid scratching and keep hands and body parts<br>from excessive moisture, follow facility protocols<br>for the treatment of injury, keep skin clean and<br>dry, and monitor/document location, size, and<br>treatment of skin injury and report abnormalities<br>to the physician.<br>The care plan lacked further specific interventions<br>(including the Roho cushion for the chair) to<br>prevent and treat skin breakdown and lacked<br>documentation the resident had a current open<br>area or a history of previous open areas.  |           | encourage good nut   | trition and hydration, and to   |          |          | · .<br>·                                  |                               |      | -                                   |
| (including the Roho cushion for the chair) to<br>prevent and treat skin breakdown and lacked<br>documentation the resident had a current open<br>area or a history of previous open areas.  |           | avoid scratching and<br>from excessive mole<br>for the treatment of<br>dry, and monitor/doo<br>treatment of skin inju        | d keep hands and body parts<br>sture, follow facility protocols<br>injury, keep skin clean and<br>cument location, size, and                        | •        |          | · ·                                       |                               |      |                                     |
|   |           | (including the Roho<br>prevent and treat sk<br>documentation the r<br>area or a history of p                                 | cushion for the chair) to<br>in breakdown and lacked<br>esident had a current open<br>previous open areas.  |          | 6        | ility ID: 1A0948                          |                               |      |                                     |

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| ND PLAN O                | FCORRECTION  | IDENTIFICATION NUMBER:   |                     | NG   | COMPLETED       |  |
|--------------------------|--|--|---------------------|--|-----------------|--|
|                          |  | 165453   | B. WING             |  | 12/03/2018      |  |
|                          | PROVIDER OR SUPPLIER   | TION & HEALTHCARE CENTER C   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>601 E POLK ST<br>WASHINGTON, IA 52353                             | ΡĒ              |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETIO |  |
| F 686                    | Continued From pa  | age 27   | F 6                 | 86   |                 |  |
|                          | Concerns" stated<br>residents with pres<br>treatment and serv<br>prevent infection, a<br>development. The<br>an order for treatm   | y policy "Identified Skin<br>the purpose was to provide<br>sure sores the necessary<br>ices to promote healing,<br>and prevent new sores from<br>policy directed staff to obtain<br>ent from the physician for each<br>lem and to complete an<br>y.  |                     |  |                 |  |
|                          | 10:00 a.m., Staff D<br>resident in the earl<br>she helped her get<br>that time the reside<br>and the resident to<br>She stated she did<br>because she thoug<br>She stated the area | y on 11/28/18 at approximately<br>stated she took care of the<br>y morning of 11/26/18 when<br>up for the day. She stated at<br>ent had an area on her bottom<br>ld her at that time it was sore,<br>not report this to the nurse<br>ht the nurses knew about it,<br>a was not open at the time and<br>ay because it was currently |                     | -  |                 |  |
|                          | DON (Director of N<br>report skin concerr<br>should call the physic<br>treatment. She sta<br>complete skin asse<br>days and should ut<br>with open wounds.                         | on 11/28/18 at 12:28 p.m. the<br>ursing) stated CNAs should<br>is to the nurse and the nurse<br>sician to proceed with a<br>ted she expected staff to<br>issments weekly or every 7-10<br>ilize a cushion for residents<br>The DON reported she would<br>skin conditions and<br>e care plan.                                       |                     |  |                 |  |
| F 689<br>SS=K            |  | azards/Supervision/Devices   | F 68                | 39   |                 |  |
|                          | §483.25(d) Accider<br>The facility must er   |  |                     |  |                 |  |

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If continuation sheet Page 28 of 40 -

| ATEMENT                  | OF DEFICIENCIES      | E & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:       |                     | ECONSTRUCTION                        |   | TE SURVEY                  |
|--------------------------|----------------------|--|---------------------|--------------------------------------|---|----------------------------|
|                          | - CONTRECTION        |  | A. BUILDING         |                                      |   |                            |
|                          |                      | 165453   | B. WING             |                                      |   | /03/2018                   |
| AME OF I                 | PROVIDER OR SUPPLIER |  | ST                  | TREET ADDRESS, CITY, STA             | TE, ZIP CODE  |                            |
| PEARL V                  | ALLEY REHABILITA     | TION & HEALTHCARE CENTER   | 0                   | )1 E POLK ST<br>ASHINGTON, IA 5235   | 3   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC      | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | (EACH CORRECTIVI<br>CROSS-REFERENCED | N OF CORRECTION<br>E ACTION SHOULD BE<br>TO THE APPROPRIATE<br>RENCY) | (X6)<br>COMPLETION<br>DATE |
| F 689                    | Continued From pa    | age 28   | F 689               |                                      |   |                            |
| 1 000                    | •                    | resident environment remains   | 1 1                 |                                      |   |                            |
|                          |                      | hazards as is possible; and  |                     |                                      |   |                            |
|                          | 8489 05(d)(0) Each   | resident receives adequate   |                     |                                      |   |                            |
|                          |                      | sistance devices to prevent  |                     |                                      |   |                            |
|                          | accidents.           |  |                     |                                      |   |                            |
|                          | This REQUIREME       | NT is not met as evidenced   |                     |                                      |   |                            |
|                          | by:                  | the second second second second  |                     |                                      |   |                            |
|                          |                      | tion, record review, and<br>ty failed to implement a safe                            |                     |                                      |   |                            |
|                          | system with regard   |  |                     |                                      |   |                            |
|                          |                      | areas, and smoking safety for  |                     |                                      |   |                            |
|                          |                      | ntified as independent   |                     |                                      |   |                            |
|                          |                      | #19, #33, #5, #16, #6). The  |                     |                                      |   |                            |
|                          |                      | to become a smoke free   |                     |                                      |   |                            |
|                          |                      | ad current residents who had   | -                   |                                      |   |                            |
|                          |                      | llity when smoking was<br>inued to do so. Prior to the                               |                     |                                      |   |                            |
|                          |                      | smoking on the grounds,  |                     |                                      |   |                            |
|                          |                      | n an enclosed courtyard that   |                     |                                      |   |                            |
|                          |                      | portunity to monitor and   |                     |                                      |   |                            |
|                          | provide supervision  | for them. The facility had   |                     |                                      |   |                            |
|                          |                      | s (via Smoking Safety Screens  | )] [                |                                      |   |                            |
|                          |                      | d smoke in a safe manner   |                     |                                      |   |                            |
|                          |                      | es or with supervision, but  |                     |                                      |   |                            |
| ł                        |                      | screens regularly or have a taff regarding which resident                            |                     |                                      |   |                            |
|                          |                      | on an independent basis. The   |                     |                                      | •   |                            |
|                          |                      | he residents to sign out to  |                     |                                      | •   | -                          |
|                          |                      | smoke, punch in a door code,   |                     |                                      |   |                            |
|                          |                      | parking lot to a grassy area   |                     |                                      |   |                            |
|                          |                      | perty where a neighbor of the  |                     |                                      |   |                            |
|                          |                      | sion for residents to spoke.<br>ned the residents were no                            |                     |                                      |   |                            |
|                          |                      | responsibility when they   |                     |                                      |   | ]                          |
|                          |                      | oked in on the lawn area just  |                     |                                      |   |                            |
|                          |                      | sidents kept their own   |                     |                                      |   |                            |
|                          | cigarettes and carr  | e and went independently to  |                     |                                      |   |                            |
|                          | that area when the   | y wished at any time of the day  |                     |                                      |   |                            |

|                          | ND PLAN OF CORRECTION  |  |                     | G   |                                       | PLETED                       |
|--------------------------|--|--|---------------------|---|---------------------------------------|------------------------------|
|                          |  | 165453   | B. WING _           | -   | 12/                                   | 03/2018                      |
|                          | PROVIDER OR SUPPLIER   | TION & HEALTHCARE CENTER   | 0                   | STREET ADDRESS, CITY, STATE, ZIP C<br>601 E POLK ST<br>WASHINGTON, IA 52353                 |                                       |                              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE                             | (X5)<br>COMPLETION<br>· DATE |
| F 689                    | or night, with no de<br>creating a hazard<br>parking lot in the n<br>fewer staff in the b<br>had the potential to<br>11/25/18, 13 inche<br>IA. The residents to<br>to side of the front<br>chairs, because the<br>with snow piles. The<br>to sign out, althoug<br>system in place to<br>out of the building<br>outside smoking. The<br>system to check the<br>outside for a perior<br>safe. This constitut | edicated smoking hours,<br>as a resident could trip in the<br>niddle of the evening when with<br>building. The parking lot also<br>o become covered with ice. On<br>is of snow fell in Washington,<br>then began smoking in an area<br>door that contained a table and<br>re grassy area was covered<br>he residents were still expected<br>gh the facility did not have a<br>monitor which residents were<br>or how long they had been<br>The facility also lacked a<br>he residents after they had been<br>d of time to see if they were<br>ted an Immediate Jeopardy (IJ)<br>and safety. The facility | 1                   | 9   |                                       |                              |
|                          | assessment tool d<br>diagnoses that incl<br>pain, and weakness<br>interview for Menta<br>that showed the re<br>cognitive abilities.<br>resident required s<br>mobility, transfers,<br>use, and personal<br>up assistance for c<br>extensive assistance<br>A 10/9/17 12:28 p.r<br>documented staff f<br>hallway on her bac  | e Minimum Data Set<br>ated 10/5/18, Resident #19 had<br>luded repeated falls, chronic<br>as and had a BIMS (Brief<br>al Status) score as 13 out of 15<br>sident demonstrated intact<br>The MDS documented the<br>supervision assist for bed<br>ambulation (walking), toilet<br>hygiene, supervision and set<br>tressing and eating, and<br>ce of 1 staff for bathing.<br>m. progress note entry<br>ound the resident lying in the<br>k. The resident stated she lost<br>umbled going to the sink to get  |                     |   | · · · · · · · · · · · · · · · · · · · |                              |

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Facility ID: IA0948

If continuation sheet Page 30 of 40

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|                          | · · · · · · · · · · · · · · · · · · ·   |   | (YOLMLET            | IPLE CONSTRUCTION  |                       | ) <u>, 0938-03</u><br>Te survey |
|--------------------------|---|---|---------------------|--|-----------------------|---------------------------------|
|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA-<br>IDENTIFICATION NUMBER:  |                     | NG   |                       | MPLETED                         |
|                          |   | 165453  | B. WING             |  | 12                    | /03/2018                        |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATI  | E, ZIP CODE           |                                 |
| PEARL V                  | ALLEY REHABILITA  | TION & HEALTHCARE CENTER  | 0                   | 601 E POLK ST<br>WASHINGTON, IA 52353                                  |                       |                                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | NTEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN<br>(EACH CORRECTIVE /<br>CROSS-REFERENCED T<br>DEFICIE | ACTION SHOULD BE      | (X5)<br>Complet<br>Date         |
| F 689                    | Continued From pa   | age 30  | F 68                | 39   |                       |                                 |
|                          |   | ntry stated the resident<br>hip and right lower extremity   |                     |  |                       | -                               |
|                          | staff observed the<br>beside the bed and  | . fall incident note documented<br>resident sitting on the floor<br>the resident reported she just<br>of the bed and did not hurt   |                     |  |                       |                                 |
|                          | found the resident of   | n. progress note revealed staft<br>on the floor, but she didn't<br>The note revealed the<br>n.  |                     |  |                       |                                 |
|                          | note entry documen<br>resident walking ba<br>DON (Director of N<br>documented anothe<br>#19 had fallen outs<br>her attempting to go<br>resident as tearful a<br>pain. The facility no | 1/9/18 on 3:45 p.m. progress<br>nted the nurse observed the<br>ick into the building with the<br>ursing). The nurse<br>er resident stated Resident<br>ide while smoking and he saw<br>et up. The nurse described the<br>and complaining of right hip<br>otified the physician and sent<br>nospital for evaluation and |                     |  |                       |                                 |
|                          | the resident returne  | n. progress note documented<br>of from the emergency room<br>soft tissue contusion (bruise).  |                     | ·  | •                     |                                 |
|                          | the resident had dro<br>clothing at home ar<br>safe to smoke with   | Safety Screen documented<br>opped cigarettes on her<br>ad assessed the resident as<br>supervision, but needed the<br>ighter and cigarettes.   |                     |  |                       |                                 |
|                          | An 11/27/18 Smoki<br>the resident as safe   | ng Safety Screen assessed<br>to smoke without   |                     |  |                       |                                 |
| M CMS-25                 | 67(02-99) Previous Versions   | Obsolete Event ID: CCO2   | 11                  | Facility ID: IA0948  | If continuation sheet | Page 31 c                       |

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| AND PLAN O               | F CORRECTION  | IDENTIFICATION NUMBER:  | 1, ,              |    | Li Ouko (Keel) (m  | CO               | MPLETED                    |
|--------------------------|---|---|-------------------|----|--|------------------|----------------------------|
|                          |   | 165453  | B. WING           | )  |  | 12               | 2/03/2018                  |
|                          | ROVIDER OR SUPPLIER   | TION & HEALTHCARE CENTER (  | )                 | •  | STREET ADDRESS, CITY, STATE; ZIP CO<br>601 E POLK ST<br>WASHINGTON, IA 52353                     |                  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION}   | ID<br>PREF<br>TAG |    | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | HOULD BE         | (X5)<br>Completion<br>Date |
| F 689                    | lighter and cigaret<br>The facility lacked<br>Screen between th<br>11/27/18. Review of<br>revealed no screen<br>11/9/18 and 11/27/<br>Department repression<br>11/26/18.<br>Care plan entries in<br>the resident as at<br>history of falls and<br>the resident as at<br>history of falls and<br>the resident would<br>review date. The of<br>experienced impais<br>ensure appropriate<br>and also document<br>independently with<br>The resident's card<br>resident smoking of<br>staff to monitor the<br>went outside to sm<br>Review of the facil<br>resident did not sig<br>During an interview<br>Resident #19's hea<br>he could not tell with<br>she was not standit<br>to staff and they as | eeded the facility to store her<br>tes.<br>an updated Smoking Safety<br>he dates of 7/20/17 and<br>of the resident's record<br>in from the time of the fall on<br>(18, which occurred after the<br>sentative entered the building<br>nitiated 5/12/16, documented<br>high risk for falls related to a<br>narcotic use, with the goal that<br>be free of injury through the<br>are plan revealed the resident<br>red vision and directed staff to<br>e visual aids glasses available,<br>ted she ambulated<br>a walker.<br>e plan did not address the<br>or provide a plan or directive for<br>e resident's safety when she<br>toke.<br>ity sign out log revealed the<br>mout of the facility on 11/9/18.<br>w on 11/28/18 at 9:45 a.m.,<br>he was in the dining room and<br>bok out the window and saw<br>ad pop up in view. He stated<br>hat position she was in but that<br>ng. He immediately reported it<br>sisted her. He stated he didn't<br>ave happened to the resident | F                 |    |  |                  |                            |
| ORM CMS-25               | 37(02-99) Previous Version  | s Obsolele Event ID: CCO21  | 1                 | Fa | cility ID: IA0946 If cor   | itinuation sheel | Page 32 of 40              |

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/09/2019 FORM APPROVED

| CENTE                                    | RS FOR MEDICARE  | & MEDICAID SERVICES   |                      |    | (  | <u>)MB NO</u> | <u>. 0938-0391</u>         |
|--|--|---|----------------------|----|--|---------------|----------------------------|
|  | FOF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MUI<br>A. BUILE |    | LE CONSTRUCTION  |               | e survey<br>IPleted        |
|  |  | 165453  | B. Wing              |    | · · · · ·  | 12/           | 03/2018                    |
| NAME OF                                  | PROVIDER OR SUPPLIER   | ······································  |                      | Ę  | STREET ADDRESS, CITY, STATE, ZIP CODE  |               |                            |
| PEARL                                    | ALLEY REHABILITA   | TION & HEALTHCARE CENTER C  | -                    |    | 601 E POLK ST<br>NASHINGTON, IA 52353  |               |                            |
| · (X4) ID<br>PREFIX<br>TAG               | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG   |    | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D 8E          | (X5)<br>COMPLETION<br>DATE |
| F 689                                    | resident stated she<br>happened when sh<br>ended up with her v   | ge 32<br>on 11/28/18 at 10:00 a.m., the<br>didn't remember what<br>e fell outside. She stated she<br>valker behind her and reported<br>perhaps 5-10 minutes.  | Fe                   | 89 |  |               |                            |
|  | Staff E LPN (Licens<br>she did not give the<br>11/9/18 before her t<br>the only other nurse<br>During an Interview<br>Staff F LPN stated   | on 11/28/18 at 11:45 a.m.,<br>sed Practical Nurse) stated<br>resident her cigarettes on<br>fall, and reported Staff F was<br>on duty at that time.<br>on 11/28/18 at 12:13 p.m.,<br>she did not give the resident<br>1/9/18 before her fall.  |                      |    |  |               |                            |
|  | resident stated she<br>lighter in her coat p<br>surveyor an almost<br>lighter in her pocket  | on 11/28/18 at 12:30 p.m., the<br>kept her cigarettes and a<br>ocket and then showed the<br>full pack of cigarettes and a<br>t.<br>on 12/3/18 at 1:20 p.m., the   |                      |    |  |               |                            |
|  | DON stated Reside  | nt #5 notified her of the<br>/9/18 and she went outside to  |                      |    |  |               |                            |
| L. L | 12/5/18 after the su<br>exited the building,<br>documented statem<br>approximately 3 - 3<br>facility's Business C<br>resident enter the c<br>documented she low<br>opened the door to<br>make a mental note<br>the building. At that | additional information on<br>rveyors shared findings and<br>Included was the following<br>nent: on 11/9/18 at<br>15 p.m. the facility's the<br>Office Manager heard a<br>ode to the front door. She<br>oked to see when someone<br>ensure customer service and<br>of any residents that exited<br>time, she wrote, Resident #19<br>ocket, had her walker, and was |                      |    | •  |               |                            |

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

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Facility ID: IA0948

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If continuation sheet Page 33 of 40

|                          | FCORRECTION  | IDENTIFICATION NUMBER:  |                     | 16 <u></u>                                   |  |   |     | PLETED                     |
|--------------------------|--|---|---------------------|--|--|---|-----|----------------------------|
|                          |  | 165453  | B. WING _           |  |  |   | 12/ | 03/2018                    |
|                          | PROVIDER OR SUPPLIER   | TION & HEALTHCARE CENTER C  |                     | STREET ADDRES<br>601 E POLK ST<br>WASHINGTON | S, CITY, STATE, ZI   | P CODE  |     |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH (                                      | VIDER'S PLAN OF (<br>CORRECTIVE ACT<br>EFERENCED TO T<br>DEFICIENC | ion should b<br>'he appropri/                 |     | (X5)<br>Completion<br>Date |
| F 689                    | information related<br>formal or informal p<br>a later time or notify<br>staff could monitor<br>2. The MDS dated<br># 5 had diagnoses<br>dementia, weaknes<br>The MDS stated the<br>assistance with bed<br>and personal hygie<br>assistance with eat<br>listed the resident's                    | statement did not contain any<br>to witnessing the fall or a<br>plan to check on the resident at<br>y staff after a period of time so<br>the resident's whereabouts.<br>9/3/18, documented Resident<br>that included non-Alzheimer's<br>is, restlessness, and agitation.<br>e resident required supervision<br>i mobility, transfers, walking,<br>ne and supervision and setup<br>ing and bathing. The MDS<br>BIMS score as 14 out of 15, | F 6                 | 39   | · ·  |   | •   |                            |
| 7                        | cognition.<br>A Smoking Safety S<br>the resident was sa<br>supervision and did<br>his lighter and cigar<br>A Smoking Safety S<br>documented the res<br>without supervision<br>store his lighter and<br>The facility lacked a<br>Screen between the<br>(the survey week).<br>A care plan entry, d | Screen, dated 11/27/18,<br>sident was safe to smoke<br>, but needed the facility to   | •                   |  | •  |   |     |                            |
|                          | resident stated he k   | on 11/28/18 at 1:08 p.m., the<br>ept his cigarettes and lighter<br>stured, indicating they were in  |                     |  |  | ··· <i>·</i> ································ |     |                            |

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Facility ID; IA0948

If continuation sheet Page 34 of 40

|   |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                            |                                 |  | FORM        | APPROVED<br>0938-0391                 |
|---|--|--|----------------------------|---------------------------------|--|-------------|---------------------------------------|
| STATEMENT OF  | DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) Multii<br>A. Building | PLE CONSTRUCTION                | `````````````````````````````````  | (X3) DATE   | SURVEY<br>PLETED                      |
| •   |  | 165453   | B. WING                    |                                 | •  | 12/0        | 3/2018                                |
| NAME OF PRO   | VIDER OR SUPPLIER  |  |                            | STREET ADDRESS, CIT             | Y, STATE, ZIP CODE   |             |                                       |
| PEARL VAL   | Ley Rehabilitat  | ION & HEALTHCARE CENTER C  | <b>)</b>                   | 601 E POLK ST<br>WASHINGTON, IA | 52353  |             | -                                     |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | id<br>Prefix<br>Tag        | (EACH CORR                      | 'S PLAN OF CORRECTIC<br>ECTIVE ACTION SHOULI<br>ENCED TO THE APPROF<br>DEFICIENCY) | ) BE        | (X5)<br>COMPLETION<br>DATE            |
| his<br>3.<br>#3<br>sci<br>rev<br>se<br>wa<br>hyp<br>Bill<br>co<br>A S<br>the<br>srr<br>fac<br>A c<br>sto<br>bac<br>Du<br>ress<br>in I<br>por<br>4.<br>list<br>heat<br>sta | 3 had diagnoses<br>hizophrenia, and<br>vealed the residen<br>tup assistance for<br>alking, dressing, e<br>giene. The MDS of<br>MS score as 15 of<br>gnition.<br>Smoking Assessing<br>e resident did not<br>hoking and stated<br>cility to store his li-<br>care plan entry, dis<br>ored the resident's<br>ck nursing station<br>wring an interview<br>sident stated he k<br>his room and ges<br>cket currently.<br>The MDS assess<br>red diagnoses for<br>art failure, obesity<br>atted the resident r | MDS dated 11/2/18, Resident<br>that included weakness,<br>depression. The MDS<br>int required supervision and<br>r bed mobility, transfers,<br>ating, toilet use, and personal<br>documented the resident's<br>ut of 15, indicating intact<br>ment, dated 6/13/18, stated<br>require supervision while<br>the resident needed the<br>ghter and cigarettes.<br>ated 3/3/17, stated the facility<br>is smoking supplies at the<br>n.<br>on 11/28/18 at 1:10 p.m., the<br>ept his cigarettes and lighter<br>tured they were in his coat<br>sment tool, dated 9/9/18,<br>Resident #6 that included<br>v, and weakness. The MDS<br>required supervision and | F 68                       | >                               |  |             | · · · · · · · · · · · · · · · · · · · |
| ass<br>rev<br>15  | sistance of 1 staff<br>vealed the resider<br>, indicating intact   | -  |                            |                                 |  |             |                                       |
| res<br>but<br>ligt  | sident as safe to a  |  | <u></u>                    | aciliiy ID: IA0948              | If continue  | ion sheet D | age 35 of 40                          |

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PRINTED: 01/09/2019

| AND PLAN OF CORRECTION   |  | DN IDENTIFICATION NUMBER:   |                     | NG   | ***   | COMPLETED          |  |
|--------------------------|--|---|---------------------|--|---|--------------------|--|
|                          |  | 165453  | 165453 B. WING      |  |   | 12/03/2018         |  |
|                          | PROVIDER OR SUPPLIER   | TION & HEALTHCARE CENTER  | 5                   | STREET ADDRESS, CITY, S<br>601 E POLK ST<br>WASHINGTON, IA 523 |   | CODE               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | id<br>Prefi)<br>TAG | X (EACH CORRECT<br>CROSS-REFERENC                              | LAN OF CORRECTION<br>IVE ACTION SHOULD BE<br>ED TO THE APPROPRIA<br>FICIENCY) |                    |  |
| F 689                    | Continued From p   | age 35  | .F 6                | 89   |   |                    |  |
|                          | resident was safe  | ing Safety Screen stated the<br>to smoke without supervision,<br>ility to store his cigarettes and  |                     |  | •   |                    |  |
|                          |  | an updated Smoking Safety<br>ne dates of 6/7/17 and 11/27/18  |                     |  |   |                    |  |
|                          | perform a Smokin<br>3/3/17 entry docun   | dated 8/20/18, directed staff to<br>g Safety Screen quarterly. A<br>nented the facility stored the<br>g supplies at the back nurses   |                     |  |   |                    |  |
|                          | resident stated he   | v on 11/28/18 at 1:05 p.m., the<br>kept his cigarettes and lighter<br>owed them to the surveyor.  |                     |  |   |                    |  |
|                          | Resident #16 had<br>obesity, weakness<br>MDS revealed the<br>and set up assistant<br>walking, dressing a<br>assistance of 1 sta<br>hygiene, and bathin | he MDS dated 10/3/18,<br>diagnoses that included morbid<br>, and difficulty walking. The<br>resident required supervision<br>nce for bed mobility, transfers,<br>and eating, and extensive<br>ff for toilet use, personal<br>ng. The MDS listed the<br>ore as 15 out of 15 indicating |                     |  |   |                    |  |
|                          | revealed Resident<br>smoke due to burn<br>smoking at home.   | Screen, dated 8/21/17,<br>#16 required supervision to<br>s noted on her body from<br>The screen also documented<br>tore her lighter and cigarettes.   |                     |  |   |                    |  |
| ŕ                        |  | Screen, dated 11/27/18,<br>ent as safe to smoke without   |                     |  |   |                    |  |
| ORM CMS-25               | 67(02-99) Previous Versions  | Obsolete Event (D; CCO21  | 1                   | Facility ID: IA0948  | If continuation s   | heet Page 36 of 40 |  |

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| PRINTED: | 01/09/2019 |
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| FORM A   | PPROVED    |

|                          |   | AND HUMAN SERVICES  |                             |   | FORM     | APPROVED<br>0, 0938-0391   |
|--------------------------|---|---|-----------------------------|---|----------|----------------------------|
| STATEMENT                | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPI<br>A. BUILDING | LE CONSTRUCTION   | (X3) DA  | te survey<br>Mpleted       |
|                          |   | 165453  | B. WING                     | · · · · · · · · · · · · · · · · · · ·   | 12       | /03/2018                   |
| NAME OF I                | PROVIDER OR SUPPLIER  | · · ·   | 1                           | STREET ADDRESS, CITY, STATE, ZIP CO   |          |                            |
| PEARL                    | ALLEY REHABILITAT   | TION & HEALTHCARE CENTER C  | )   '                       | 01 E POLK ST<br>NASHINGTON, IA 52353  |          | -                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AL<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 689                    | cigarettes.<br>The facility lacked a<br>Screen between the<br>11/27/18 (the surver<br>A care plan entry, d<br>assess safety with s<br>quarter.<br>A list the facility pro-<br>entrance on 11/26/1<br>and #33 as indepen-<br>not include Residents<br>or include Residents<br>or the facility Indepen-<br>11/27/18 directed the<br>materials locked in<br>and stated residents<br>of the facility with nu-<br>possession of the s<br>stated nursing staff<br>residents every 30 r<br>checks when sever<br>In an interview on 1<br>corporate nurse cor-<br>of the assessments<br>were updating them<br>system directed residents<br>went to smoke so the<br>facility's responsibilities and the subsequent interview.<br>In a subsequent interview. | an updated Smoking Safety<br>e dates of 8/21/17 and<br>y week).<br>ated 8/20/18, directed staff to<br>smoking independently each<br>vided to the survey team upon<br>18 listed Residents #5, #6, #16<br>ident smokers. The list did<br>it #19 as an independent<br>dent Smoking Policy, dated<br>he facility would keep smoking<br>a designated secured location<br>is would sign themselves out.<br>ursing staff upon taking<br>moking materials. The policy<br>would check on the the<br>minutes and would increase<br>e weather dictated.<br>1/27/18 2:30 pm, the<br>nsultant acknowledged some<br>were not up to date, but staff<br>i. She reported the facility's<br>idents sign out when they<br>ney were then outside of the<br>ity. | F 689                       |   |          |                            |
|                          | same day, she state   | ximately 3:00 p.m. on the<br>ed the facility would revise<br>ng forward, the nurse would  |                             |   |          |                            |

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If continuation sheet Page 37 of 40

| ame of i                 | PROVIDER OR SUPPLIER  | 165453   |                     | EET ADDRESS, CITY, STATE, ZIP CODE  | 12/03/2018        |
|--------------------------|---|--|---------------------|---|-------------------|
| EARLV                    | ALLEY REHABILITA  | TION & HEALTHCARE CENTER C   | i                   | SHINGTON, IA 52353  |                   |
| (X4).ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE COMPLETION |
| F 689                    | Continued From pa   | age 37   | F 689               |   |                   |
|                          | keep the sign out b   | book so she will know who went<br>uld then check on the residents  |                     |   |                   |
|                          | Nurse Consultant s<br>really understood t<br>materials. She sta   | 11/28/18 at 5:30 p.m., the<br>stated she didn't think the staff<br>he idea of keeping the smoking<br>ted the nurses would now<br>sidents returned the cigarettes<br>m outside.   |                     |   |                   |
| •                        | Administrator state<br>courtyard area bec<br>free." She then sho<br>near the front door<br>stated this was who<br>currently since the<br>snow. She then sh<br>the east end of the<br>that contained piles<br>consultant stated it | y on 11/27/18 at 3:30 p.m., the<br>d the facility stopped using the<br>ause the facility went "smoke<br>owed the surveyor the area<br>with a small patio table and<br>ere the residents smoked<br>other area was covered with<br>lowed the surveyor an area at<br>parking lot between 2 vehicles<br>of snow. The nurse<br>was the neighbor's area and<br>sidents to smoke there when it<br>snow. |                     |   |                   |
|                          | all-totals-from-Nove  | om/content/news/WWC-Snowf<br>ember-25-2018-501251021.ht<br>shington received 13 inches<br>8.   |                     | ,   |                   |
|                          | The facility abated implementing the fo   | the IJ on 11/28/18 by<br>bliowing actions:   |                     | · .   |                   |
| -                        | safety assessment.<br>2. New BIMS asses<br>residents (Done on   | lents to receive smoking<br>(Completed 1/27/18)<br>ssment of all smoking<br>11/28/18)<br>nt rooms for smoking materials  | · ·                 |   | ······            |

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|                          |   | I AND HUMAN SERVICES   |                     | · · ·  | FORM     | : 01/09/201<br>APPROVE<br>0938-039 |
|--------------------------|---|--|---------------------|--|----------|------------------------------------|
|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION   |          | e survey<br>IPleted                |
|                          |   | 165453   | B, WING             | <u> </u>   | 12/      | 03/2018                            |
| NAME OF F                | PROVIDER OR SUPPLIER  | <u> </u>   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  | <u> </u> |                                    |
| PEARL V                  | ALLEY REHABILITAT   | TION & HEALTHCARE CENTER (   | ו ר                 | 601 E POLK ST<br>WASHINGTON, IA 52353  |          |                                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE    | (X5)<br>COMPLETION<br>DATE         |
| F 689                    | protocols. (11/28/18<br>5. Residents will be<br>of checking out the<br>(11/28/2018)   | (11/28/18)<br>ated regarding smoking   | F 689               | )  |          | · · ·                              |
|                          | be checked on by n<br>been out for 30 min<br>weather.<br>7. Residents that ar<br>smokers will be allo<br>that they have signe   | ursing staff after they have<br>unless severe or inclement<br>re deemed to be independent<br>wed to smoke per the policy   |                     |  |          |                                    |
| E 200                    | removing smoking i<br>2. Audit of the check<br>smoking.   | heets for the residents  | r oco               |  |          |                                    |
| SS=D                     | §483.75(g)(1) A faci<br>assessment and as<br>at a minimum of:<br>(i) The director of nt<br>(ii) The Medical Dire<br>(iii) At least three of<br>staff, at least one of | assessment and assurance.<br>ility must maintain a quality<br>surance committee consisting<br>ursing services;<br>ector or his/her designee;<br>her members of the facility's<br>who must be the | F 868               |  |          |                                    |
|                          | individual in a leade   | uality assessment and<br>ee must:  |                     | cility ID: IA0948 If continua  |          | Page 39 of 4                       |

|                          |   |   |  | A. BUILDING |  |        |                        |  |
|--------------------------|---|---|--|-------------|--|--------|------------------------|--|
|                          |   | 165453  | B. WING  |             |  | 12/    | 03/2018                |  |
|                          | PROVIDER OR SUPPLIEI  | R<br>ATION & HEALTHCARE CENTER C  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>601 E POLK ST<br>WASHINGTON, IA 52353 |             |  |        |                        |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG  | < c         | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>ROSS-REFERENCED TO THE APPF<br>DEFICIENCY) | ULD BE | (X5)<br>COMPLE<br>DATE |  |
| F 868                    | identifying issues<br>assessment and a<br>necessary.<br>This REQUIREMI<br>by:<br>Based on record<br>failed to provide of<br>Quality Assurance<br>survey and failed<br>number of person<br>Meetings. The fac<br>residents.<br>Findings include:<br>1. At survey entr<br>Self-Identified and<br>on 10/30/18, reve<br>unable to locate p<br>data.<br>The facility provid<br>conference forms<br>Registered Nurse<br>16 of 2018 and Ap<br>The Administrator<br>Quarterly QA meet<br>that revealed the a<br>QA meeting had a<br>In an interview on<br>Consultant date o<br>Administrator had<br>However, the doc | uarterly and as needed to<br>with respect to which quality<br>assurance activities are<br>ENT is not met as evidenced<br>review and interview, the facility<br>locumentation for quarterly<br>e (QA) meetings since last<br>to ensure the appropriate<br>anel attended the Quarterly QA<br>cility identified a census of 37<br>ance, the facility provided the<br>d Correction Form documented<br>aled the new Administrator was<br>ast QA monthly and/or quarterly<br>ed Quality Assurance phone<br>signed by the consultant, the<br>and the Physician dated March<br>oril 16 2018.<br>provided documentation for the<br>etings on 10/30/18 and 11/20/18<br>appropriate staff required for the<br>attended.<br>11/28/18 10:55 AM, the Nurse<br>f hire 2/20/18 revealed the<br>located several sign in sheets.<br>uments lacked dates of the<br>1 to identify the type of meeting | F 8  | 68          |  |        |                        |  |

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# Plan of Correction Pearl Valley Rehab

Annual Survey November 26-December 3, 2018

The statements made in the 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 regulators the facility has or will take the following actions set forth in the plan of correction.

## F623: Notice requirements before transfer/discharge

The facility will continue to notify the state long term care ombudsman of discharges to the hospital. The facility failed to send a notice of the discharge to the office of the State Long-Term Care Ombudsman. The Administrator, Director of Nursing & Business Office Manager received education from the regional nurse consultant on December 3rd, 2018 regarding the notification process for the ombudsman. The business office manager or administrator will notify the state long term care ombudsman of discharges monthly. The administrator and/or designee will audit the notifications to the ombudsman office on a monthly basis for three (3) months. Audit results will be brought to the QA meeting for three (3) months.

## F656:Develop/Implement Comprehensive Care Plan

The facility does and will continue to maintain development and implementation of comprehensive care plans. The facility failed to address specific areas of care regarding activities, pain, and potential for or actual pressure sores on the comprehensive care plan. The activity director received care plan training on December 28th, 2018 from the administrator. The activity director was educated on how to write individual care plans, charting assessment notes, reviewing care plans and how to update care plans, 1:1 activity requirements and documentation. Nursing staff received education on January 3rd, 2019 from the Director of Nursing on notifying nurses of any skin conditions that they notice so that the nurses can notify the physician regarding a treatment plan. Nurses assigned by the Director of Nursing will complete skin assessment every seven (7) to ten (10) days and will update the skin charting notes and notify the Director of Nursing regarding skin conditions and the Assistant Director of Nursing/MDS coordinator will also be notified of changes so that necessary updates will be on the care plan. Nursing staff also received education on January 3rd, 2019 for pain management on from the Director of Nursing on signs and symptoms of residents pain, including verbal and nonverbal signs of pain, documentation notifying the physician of possible changes to pain treatment plans and to notify the Assistant Director of Nursing/MDS coordinator so that updates will be on the care plan. The administrator and/or designee will audit activity care plans on a weekly basis for four (4) weeks, then every two (2) weeks for a month and then monthly for two (2) months. The Director of Nursing and/or designee will audit skin and pain care plans on a weekly basis for four (4) weeks, then every two (2) weeks for a month, and then monthly for two (2) months. Audit results will be brought to the QA meeting for four (4) months.

#### F658: Services Provided Meet Professional Standards

The facility does and will continue to have services provided meet professional standards. The facility staff failed to follow professional standards of medication administration for a resident with G tube medications. Nursing staff educated on January 3rd, 2019 by the Director of Nursing that when distributing medications thru a g-tube that the g-tube placement is checked prior to giving medications and that the nurse will follow the facility flushing policy of meds thru the g-tube unless the physician has ordered a different procedure. Nursing staff also educated that prior to giving a resident medication that they need to check the bubble pack, the MAR and identify the resident.

#### F661: Discharge Summary

The facility will complete discharge summaries for residents when the discharge from the facility. The facility failed to complete a recapitulation of discharged residents. The nursing staff and care plan team received training on regarding how to complete the recapitulation summary for residents, that will include any discharge or transfer instructions/information, recapitulation of stay, or medication distribution at the end of the resident's stay in the facility. The Assistance Director of Nursing/MDS coordinator will open up the discharge summary in PCC prior to discharge so that all necessary departments are able to complete their discharge charting on resident. The Administrator and/or designee will audit discharge summaries weekly for four (4) weeks, then every two (2) weeks for a month, and then monthly for two (2) months. Audit results will be brought to the QA meeting for four (4) months.

# F679: Activities Meet Interest/Needs Each Resident

The facility does and will continue to provide activities that meet interest/needs of each resident. The facility failed to provide and document the involvement of activities. The Activity Director received training on December 28th, 2018 regarding documentation of attendance at activities, including those that are receiving 1:1 activities from the activity director. The Administrator and/or designee will audit activity attendance and involvement weekly for four (4) weeks, then every two (2) weeks for a month and then monthly for two (2) months. Audit results will be brought to the QA meeting for four (4) months.

#### F685: Treatment/Devices to Maintain Hearing/Vision

The facility does and will continue to provide treatment/devices to maintain hearing/vision. The facility failed to ensure a resident with impaired vision received proper treatment and assistive devices to maintain their vision. When resident MDS's are due, or at care plan meetings, facility staff will ask residents about their vision needs and if they're wanting to see a eye doctor. If so, facility will coordinate with resident representatives regarding setting up an appointment at the eye doctor of their choice & arrange transportation as well. The Assistant Director of Nursing/MDS coordinator will update the care plan to show date of vision or hearing appointments. The Director of Nursing and/or designee will audit vision

assessments weekly for four (4) weeks, then every two (2) weeks for a month and then monthly for two (2) month. Audit results will be brought to the QA meeting for four (4) months.

### **F686:** Treatment/Svcs to Prevent/Heal Pressure Ulcer

The facility does and will continue to provide treatment/services to prevent/heal pressure ulcer. The facility failed to properly assess and carry out interventions to prevent a pressure ulcer. Nursing staff received education on from the Director of Nursing on notifying nurses of any skin conditions that they notice so that the nurses can notify the physician regarding a treatment plan. Nurses assigned by the Director of Nursing will complete skin assessment every seven (7) to ten (10) days and will update the skin charting notes and notify the Director of Nursing regarding skin conditions and the Assistant Director of Nursing/MDS coordinator will also be notified of changes so that necessary updates will be on the care plan. The Director of nursing and/or designess will audit skin assessments weekly for four (4) weeks, then every two (2) weeks for a month, and then monthly for two (2) months. Audit results will be brought to the QA meeting for four (4) months.

#### F689: Free of Accident Hazards/Supervision/Devices

The facility does and will continue to ensure that residents are free of accident hazards/ supervision/ devices. The facility failed to implement a safe smoking system with regard to smoking, smoking areas, and area and smoking safety. The facility has revised the smoking policy so it is a supervised smoking policy. The current policy is for all smoking residents to receive a smoking safety assessment, a BIMS assessment and that residents are educated on the smoking protocols; including checking out their cigarettes from the nurse and signing them back in after smoking. A staff member is to take them out for smoking where they will smoke in the front patio area and will remain with them during that time. Each quarter when a resident MDS is due, a smoking safety screen will be updated to ensure the resident remains a safe smoker and a BIMS will be update as well to review cognition. Therapy will also evaluate them for their abilities with ambulation or using a device to go outside. The Assistant Director of Nursing/MDS coordinator will update their care plan as needed with updates from the safety screen, BIMS and therapy evals. The Director of Nursing and/or designee will audit the safety screens, BIMS, and therapy evals when MDS's are due to ensure that the resident remains safe to smoke. The Director of Nursing and/or designee will complete weekly audits for four (4) weeks, then every two (2) weeks for a month, and then monthly for two (2) months. Audit results will be brought to the QA meeting for four (4) months.

#### F868: QAA Committee

The facility does and will continue to maintain QAA committee. The facility failed to provide appropriate number of personnel attended the Quarterly QA Meetings. The administrator will schedule

monthly QA meetings and the Director of Nursing or the Assistant Director of Nursing will arrange quarterly QA meetings with the Medical Director. The Administrator and/or designee will audit monthly 'QA meetings and attendance for six (6) months. Audit results will be brought to the QA meeting to six (6) months.