STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 1-7-18 ✓ qm The following deficiencies relate to the annual recertification and State Licensure Survey and investigation of complaints 79633-C and 78972-C conducted on 11-26-18 thru 11-29-18. Both complaints were not substantiated. See code of Federal Regulations (42 CFR) Park 483, Subpart B-C.	F 000		
F 623 SS=D	Amended 1/2/19 by JKM, RN Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		12/28/2018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 1 discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual	F 623		

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F 623	Continued From page 2 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to send a notice of the discharge to the office of the State Long-Term Care Ombudsman for 3 of 3 residents reviewed	F 623		

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F 623	Continued From page 3 (#30, #41, #42). The facility reported a census of 37 residents. Findings include: 1. The Minimum Data Set (MDS), dated 10/26/18, listed Resident #30's cognition as moderately impaired. The MDS listed the following diagnoses for Resident #30: schizophrenia, delirium, anxiety disorder, and aphasia (the loss of ability to understand or express speech). A progress note entry, dated 10/19/18, stated the resident transferred to the hospital emergency room. A progress note entry, dated 10/22/18, stated the resident returned to facility. The facility lacked documentation of notification of Ombudsman notification of the transfer to the hospital. The undated facility policy directed staff to notify the ombudsman monthly of resident transfers/discharges monthly. During an interview on 11/28/18, the nurse consultant stated the facility did not notify the ombudsman of transfers and stated they identified this as a problem. 2. The MDS dated 10/26/18 revealed Resident #41 had diagnoses that included: hypo-osmolality, hyponatremia (low sodium), hypothyroidism, GERD (gastric reflux or heartburn), hypertension, weakness, and difficulty walking.	F 623		

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F 623	Continued From page 4 Resident # 41's medical record failed to provide any information regarding notification of the Ombudsman upon transfer to the hospital or discharge from the facility. On 11/29/18, the Administrator for the facility confirmed the facility did not notify the Ombudsman of the residents transfer/discharge. 3. The MDS dated 09/12/18 revealed Resident # 42 had diagnoses that included asthma, respiratory failure, dysphasia, heart disease, rheumatoid arthritis, and shortness of breath. Resident # 42's medical record failed to provide any information on the notification of the discharge to the Ombudsman. The undated facility policy for Resident Transfer Guidelines directed staff to notify the Ombudsman of resident transfers/discharges on a monthly basis.	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		

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F 656	Continued From page 5 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interview, the facility failed to address specific areas of care regarding activities, pain, and potential for or actual pressure sores on the comprehensive care plan for 3 of 12 residents reviewed (Resident #1, #19, and #22). The facility reported a census of 37 residents.	F 656		

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F 656	Continued From page 6 Findings include: 1. According to the Minimum Data Set (MDS) assessment tool dated 8-11-2018, Resident #1 had diagnoses of hemiplegia, hypertension, pneumonia, aphasia (difficulty or inability , stroke, non-traumatic intracerebral hemorrhage, unspecified and dysphasia. A Brief Interview for Mental Status (BIMS) was not assessed. The MDS documented the resident as totally dependent on 2 staff for all activities of daily living which included bed mobility, transfers, dressing, toilet use, and personal hygiene. The care area assessment (CAA) identified focus areas that included activities, psychosocial well-being, feeding tube, and pain. The resident's care plan lacked any documentation or directives to staff regarding an individualized activity plan. In an interview on 11-27-18 at 11:40 am, the Nurse Consultant acknowledged the lack of activities addressed on the resident care plan, and reported a new activity staff member had worked for 3 weeks attempting to catch up as the former activity director left in October 2018. The Nurse Consultant stated care plans are updated quarterly unless there is a reason specific i.e.: falls, urinary tract infection. In an interview with the Administrator on 11/28/18 09:04 AM, she verified the lack of documentation on any activities or any staff of activity staff 1:1 with Resident #1. The Administrator reported the former activity director had engaged with the resident by reading to him or providing music, but no documentation of that was provided by the facility. The Administrator reported the new	F 656		

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F 656	Continued From page 7 activity director started working at the facility 3 weeks ago and planned to address the lack of activity or activity log for the resident. 2. According to the MDS dated 10/3/18, Resident #22 had diagnoses that included diabetes, difficulty walking, and chronic kidney disease. The MDS documented the resident required limited assist of 1 staff for eating and extensive assist of 1 staff for transfers, walking, dressing, toilet use, and personal hygiene. The MDS also documented Resident #22 required extensive assistance of 2 staff for bed mobility, and was totally dependent on 1 staff for bathing. The MDS identified the resident's BIMS (Brief Interview for Mental Status) score as 14 of 15, indicating intact cognition and documented the resident was at risk of developing pressure ulcers. During an observation on 11/27/18 at 8:05 a.m., the surveyor walked by the resident sitting at the breakfast table and the resident stated to the surveyor she had some "spots" on her bottom and was in pain. The resident sat in a dining room chair and had no pad under her. During an observation on 11/27/18 at 8:22 a.m., the resident sat in a chair without a cushion under her in the activity room. Subsequent observations revealed the resident in the activity room chair at 8:55 a.m. and 9:22 a.m. During an observation on 11/27/18 at 10:03 a.m., Staff C CNA (Certified Nursing Assistant) entered the room as the resident sat in a recliner. The resident told Staff C her bottom hurt. The resident stood up and had an approximate dime sized red area on the right buttock which appeared to be missing layers of skin. The area was surrounded by white flakes and the resident's	F 656		

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F 656	Continued From page 8 entire right buttock was reddish purplish in color. Staff C mixed A and D Ointment and Peri Guard (ointments used to treat skin irritation) and applied this to the area, then the resident sat back down in the recliner. Staff A stated she would tell the nurse and they would try to obtain an order for something additional (skin treatment). The resident stated the area hurt so bad she could not sleep the previous night. The resident's recliner was covered with a cloth incontinence pad and did not appear to have a cushion present. Following the cares, Staff C stated to the surveyor she was not exactly sure how long the resident had the area but thought is was approximately 1 week. During an observation on 11/27/18 at 12:30 p.m., the resident sat in a chair at the lunch table with no cushion under her. During an observation on 11/27/18 at 2:30 p.m., the resident sat in her recliner. The recliner did not appear to have a cushion in it. During an observation on 11/28/18 at 8:45 a.m., Staff D CNA assisted the resident to stand up from her recliner as Staff A LPN (Licensed Practical Nurse) measured a red open wound on the resident's right buttock, which measured 1 cm(centimeter) x 1.25 cm with a thin red trail measuring 0.5 cm. Staff D commented the resident had something on her bottom on Monday (11/26/18) when she took care of her, but it was not open at that time. After Staff A measured the area, the resident sat down in the recliner which had a visible, thick black cushion in it. Staff A stated the black cushion was a Roho (a thick cushion used to prevent and treat pressure ulcers) and they took out the "gel one" yesterday	F 656		

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F 656	Continued From page 9 as she pointed to the counter. On the counter was a thin (approximately 1 cm thick) yellow gel cushion. A 9/21/18 9:17 a.m. progress note stated the resident had an open area on the right buttocks approximately 1 cm round, superficial and the resident reported discomfort when sitting. A 9/21/18 9:20 a.m.. progress note listed an order for an Optifoam border dressing (a foam dressing) to the right buttocks applied every other day and as needed. A 10/8/18 9:45 a.m. progress note listed an order to discontinue the Optifoam border dressing and begin Calmoseptine ointment (an ointment used to treat skin irritation) and utilize a Roho cushion in the chair. The progress note lacked any documentation of an assessment of the wound and did describe the area as healed. An 11/3/18 unsigned "Weekly Skin Assessment" had a question marked "yes" for "open cuts, lacerations, lesions, or skin tears" and documented the location as to the right buttocks and indicated the facility discontinued the treatment on 10/8/18. An 11/28/18 10:32 a.m. progress note stated the resident reported pain in her bottom and the nurse faxed the physician with regard to a treatment/dressing. The facility lacked any further assessments of the area between the dates of 9/21/18 and 11/28/18 (Wednesday of the survey week). Review of the October TAR (Treatment	F 656		

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F 656	Continued From page 10 Administration Record) revealed the resident received Calmoseptine ointment to the buttocks from 10/8/18 - 10/21/18. Review of the October and November TARS revealed the facility lacked documentation of a skin treatment to the right buttocks from 10/21/18 - 11/28/18. Record revealed no information to indicate staff notified the physician 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). 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. Care plan entries, revised 5/9/18, stated the resident was 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, encourage good nutrition and hydration, and identify potential causative factors. 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. The care plan lacked further specific interventions (including a Roho cushion for the chair)	F 656		

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F 656	Continued From page 11 implemented by the facility to prevent and treat skin breakdown and lacked documentation the resident had a current open area or a history of previous open areas. During an interview on 11/28/18 at 12:28 p.m. the DON(Director of Nursing) stated CNAs should report skin concerns to the nurse and the nurse should call the physician to proceed with a treatment. She stated staff should complete skin assessments weekly or every 7-10 days and stated staff should utilize a cushion for residents with open wounds and stated she would want the resident's skin conditions and interventions on the care plan. 3. According to the MDS dated 10/5/18, Resident #19 had diagnoses that included repeated falls, chronic pain, and weakness. The MDS stated the resident required supervision assistance for bed mobility, transfers, walking, toilet use, and personal hygiene, and supervision and set up assistance for dressing and eating, along with extensive assistance of 1 staff for bathing. The MDS listed the resident's BIMS score as 13 of 15, indicating intact cognition and stated the resident had occasional pain in the last 5 days which limited day-to-day activities. The MDS stated the resident rated the pain as a "7" on a 1-10 scale with "0" being no pain and "10" being the worst pain imaginable. During an interview on 11/26/18 at approximately 10:00 a.m., the resident stated she was hurting and had arthritis. She stated staff just gave her pain medications and she was hoping they would kick in soon.	F 656		

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F 656	Continued From page 12 During an interview on 11/27/18 at 8:39 a.m., the resident grimaced while walking from her bed to the chair. She stated staff did give her pain medications and they helped, but not completely. She stated the mornings were the worst. A pain assessment, dated 11/6/18, stated the resident had pain "almost constantly" over the last 5 days and rated the pain as a "4" on a scale of 0-10. The resident's current care plan lacked documentation of the resident's pain and lacked direction for staff regarding interventions utilized to treat the pain. The undated facility policy, "MDS/Care Plan Development Process" stated the facility would develop a comprehensive, individualized plan of care for each resident including medical, physical, and functional needs. During an interview on 11/29/18 at 9:17 a.m., the DON stated pain should be an area on the care plan and care plans were an area the facility was working to improve.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interviews, the facility staff failed to follow	F 658		

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F 658	Continued From page 13 professional standards of medication administration for 1 of 1 residents reviewed with G tube medications, and for 1 of 12 residents in the sample. (Residents #1, #22). The facility reported a census of 37 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment tool dated 8/11/18, Resident #1 had diagnoses of hemiplegia, hypertension, pneumonia, aphasia, stroke, non-traumatic intracerebral hemorrhage, and dysphasia (difficulty speaking). A brief interview for mental status was not assessed. The MDS documented the resident as totally dependent upon 2 staff for bed mobility, transfers, dressing, toilet use, personal hygiene. In an observation on 11-27-18 at 11:30 AM, Staff A crushed the following medications: Tylenol 325 milligrams (mg) 2 tabs four times day Baclofen 20 mg every 6 hours Oxycodone every 6 hours Continued observation revealed the nurse placed a barrier for supplies, washed her hands, and pulled the curtain, but failed to check tube placement. The nurse then flushed the tube with 30 ml distilled water before meds, administered Tylenol, flushed with 10 milliliters (ml) of distilled water, administered Baclofen, flushed with 10 ml water, administered Oxycodone, and then flushed the tube with 30 ml of water. The resident's care plan initiated 4/19/18 directed staff to use water flushes via PEG tube per MD orders and to notify MD for increased flushes with	F 658		

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F 658	Continued From page 14 signs of dehydration. Review of the Medication Administration Record (MAR) and Physician Order Summary for the month of November revealed no orders to crush medications. In an interview with the nurse consultant on 11/27/18 at 3 PM, she stated shed expected staff to follow facility policy on flushing unless a doctor order specified something different, and also expected nurses to follow policy on checking placement prior to administration. In an interview on 11/27/18 at 16:45 PM , Staff A acknowledged not checking the G tube for placement prior to administering of medications and crushing meds were crushed but no Dr order. An undated facility policy for administering medications per feeding tube instructed staff to check for appropriate placement and flush with 15 ml water or according to physician's orders to make sure is tube patent. If administering more than one medication that requires crushing, give one at a time and flush with at least 5 ml water between medication. Flush the tube again with 30-50 ml of water or the ordered amount to clear the tube and decrease potential for tube blockage. 2. The MDS dated 10/3/18, listed diagnoses for Resident #22 that included diabetes, incontinence, and chronic kidney disease. The MDS stated the resident required limited assistance of 1 staff for eating, extensive assistance of 1 staff for transfers, walking, dressing, toilet use, and personal hygiene and extensive assistance of 2 staff for bed mobility. The MDS listed the resident's BIMS (Brief	F 658		

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F 658	Continued From page 15 Interview for Mental Status) score as 14 out of 15, indicating intact cognition. During an observation on 11/28/18 at 8:45 a.m., Staff B CMA (Certified Medication Aide) entered the resident's room and handed Staff A LPN (Licensed Practical Nurse) a medication cup and stated it was the resident's hydrocodone (a narcotic pain medication). Staff B left the room and Staff A subsequently administered the medication to the resident. The November MAR (Medication Administration Record) listed an order for hydrocodone-acetaminophen 5-325 mg (milligrams) 1 tab every 4 hours as needed. The MAR, requested by the survey team and printed by the facility on 11/29/18, did not reflect staff administering the hydrocodone on 11/28/18 at 8:45 a.m. The undated facility policy directed staff to read the medication label 3 times and identify the resident prior to administration. During an interview on 11/29/18 at 9:17 a.m., the DON(Director of Nursing) stated nurses should not give medications they did not prepare, and should check the bubble pack and the MAR before administration.	F 658		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that	F 661		

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F 661	Continued From page 16 includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a recapitulation of Resident # 41 and 42's stay at the facility in when discharged. The facility reported a census of 37 residents. Findings include: The 90 day Minimum Data Set (MDS) dated 09/12/18 documented Resident #42's BIMS (Brief Interview of Mental Status score as 3 of 15, which indicated Resident # 42 demonstrated severe	F 661		

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F 661	Continued From page 17 long and short term memory issues. Diagnoses included asthma, respiratory failure, dysphasia, restless leg syndrome, heart disease, muscle weakness, rheumatoid arthritis, and shortness of breath. The plan of care failed to contain any discharge planning information for Resident # 42 except a staff directive to help obtain support services at discharge. The nursing progress discharge notes dated 09/14/18 failed to provide any information regarding the resident's personal items and the belongings returned, return of medications, discharge instructions/teaching, or referral information. A review of the resident's medical record failed to provide any indication facility staff completed a recapitulation of the resident's stay as required. A policy for Resident Transfer and Discharge dated 11/28/2016 directed staff to ensure the transfer/discharge information documented in the resident's medical record and the appropriate information communicated to the receiving facility. The policy also directed the information should include all information necessary for complete resident care and a discharge summary. The facility policy, Discharges to Home, dated 11/07/17 directed staff to fax medications, history and physical, Physicians visits to current Physician, follow-up instructions given, and provide the resident with a current list of medications, instructions, follow-up appointments, and any cares needed or referrals.	F 661		

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F 661	Continued From page 18 2. The Admission MDS date 09/26/18 revealed a BIMS score of 15 (both long and short term memory intact) for Resident # 41. Diagnoses included hypo-osmolality, hyponatremia, hypothyroidism, GERD, major depression, hypertension, weakness, and difficulty walking. The plan of care with an initiation date of 07/17/18 failed to have any plan or interventions for discharge planning. A discharge planning note on 11/7/2018 at 1:20 P.M., noted the resident's daughter picked up his personal belongings on 11/2./18. Review of the resident's record revealed on 10/30/2018 4:02 P.M., Resident # 41 admitted to the hospital with increased psychiatric behaviors. The County Clerk changed the resident's court committal to the hospital. Resident #41's daughter notified of transfer. The facility failed to complete any discharge or transfer instructions/information, recapitulation of stay, or medication distribution at the end of the resident's stay in the facility. On 11/29/18 09:28 AM, the facility Administrator verified no recapitulation of stay completed and reported the resident had been court committed to another facility after the hospitalization. She added Resident # 41 sent to the hospital for an appointment for increased psychiatric behaviors and hospitalized from there.	F 661		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)	F 679		

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F 679	Continued From page 19 §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to provide and document the involvement of activities for 1 of 12 residents reviewed (Resident #1). The facility reported a census of 37 residents at the time of the survey. Findings include: 1. The Minimum Data Set (MDS) dated 8-11-2018 documented diagnoses of Hemiplegia, hypertension, pneumonia, aphasia, stroke, non-traumatic intracerebral hemorrhage, unspecified and dysphasia. A brief interview for mental status was not assessed. Resident is totally dependent, requiring 2 assist for all cares including bed mobility, transfers, dressing, toileting, personal hygiene. The care area assessment (CAA) triggered activities, psychosocial well being, feeding tube and pain. An observation on 11/26 at 10:20 AM showed Resident #1 in bed with eyes open, call light in place. Observations throughout the day on 11/27/18 reflected no activities provided to the resident while in bed or in his wheelchair when he	F 679		

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F 679	Continued From page 20 sat in the common area. In an interview with the Administrator on 11/28/18 09:04 AM, she verified the lack of documentation on any activities or any staff of activity staff 1:1 with Resident #1. The Administrator reported the former activity director had engaged with the resident by reading to him or providing music, but no documentation of that was provided by the facility. The Administrator reported the new activity director started working at the facility 3 weeks ago and planned to address the lack of activity or activity log for the resident.	F 679		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 1 residents reviewed with impaired vision received proper treatment and assistive devices to maintain their vision (Resident #19). The facility reported a census of 37 residents.	F 685		

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F 685	Continued From page 21 Findings include: 1. The MDS (Minimum Data Set) assessment tool, dated 10/5/18, listed diagnoses for Resident #19 included repeated falls, chronic pain, and weakness. The MDS stated the resident required supervision assistance for bed mobility, transfers, walking, toilet use, and personal hygiene, supervision and set up assistance for dressing and eating, and extensive assistance of 1 staff for bathing. The MDS listed the resident's BIMS (Brief Interview for Mental Status) score as 13 of 15, which indicated intact cognition. The MDS listed the resident's vision as adequate and documented the resident did not wear corrective lenses. The MDS dated 12/12/17 documented the resident had adequate vision and wore corrective lenses. During an observation on 11/27/18 at 8:12 a.m., the resident walked with a walker in the hallway toward the dining room. The resident said hello to the surveyor and appear to be squinting. The resident stated to the surveyor that she could not see. The facility lacked documentation the resident had an evaluation from an eye doctor during the time period of 9/14/17 and the survey week (11/27/18) when the surveyor brought the matter to the attention of the Administrator. Care plan entries, initiated 5/12/16, revealed the resident had impaired visual function and would not show a decline in visual function through the review date. The care plan directed staff to assist with setting up eye appointments as needed and	F 685		

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F 685	Continued From page 22 ensure appropriate visual aides/glasses were available to support the resident's participation in activities. During an interview on 11/27/18 at 8:39 a.m., the resident stated she could not see. She stated she had glasses but they were "no good". During an interview on 11/29/18 at 9:17 a.m., the DON (Director of Nursing) stated the facility would develop a more formal method for assessing vision. She stated the facility should ask residents if they had any visual concerns.	F 685		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to properly assess and carry out interventions to prevent a pressure ulcer for 1 of 1 residents reviewed with a current open area. The facility reported a census of 37 residents.	F 686		

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F 686	Continued From page 23 Findings include: 1. According to the MDS dated 10/3/18, Resident #22 had diagnoses that included diabetes, difficulty walking, and chronic kidney disease. The MDS documented the resident required limited assist of 1 staff for eating and extensive assist of 1 staff for transfers, walking, dressing, toilet use, and personal hygiene. The MDS also documented Resident #22 required extensive assistance of 2 staff for bed mobility, and was totally dependent on 1 staff for bathing. The MDS identified the resident's BIMS (Brief Interview for Mental Status) score as 14 of 15, indicating intact cognition and documented the resident was at risk of developing pressure ulcers. During an observation on 11/27/18 at 8:05 a.m., the surveyor walked by the resident sitting at the breakfast table and the resident stated to the surveyor she had some "spots" on her bottom and was in pain. The resident sat in a dining room chair and had no pad under her. During an observation on 11/27/18 at 8:22 a.m., the resident sat in a chair without a cushion under her in the activity room. Subsequent observations revealed the resident in the activity room chair at 8:55 a.m. and 9:22 a.m. During an observation on 11/27/18 at 10:03 a.m., Staff C CNA (Certified Nursing Assistant) entered the room as the resident sat in a recliner. The resident told Staff C her bottom hurt. The resident stood up and had an approximate dime sized red area on the right buttock which appeared to be missing layers of skin. The area was surrounded by white flakes and the resident's	F 686		

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F 686	Continued From page 24 entire right buttock was reddish purplish in color. Staff C mixed A and D Ointment and Peri Guard (ointments used to treat skin irritation) and applied this to the area, then the resident sat back down in the recliner. Staff A stated she would tell the nurse and they would try to obtain an order for something additional (skin treatment). The resident stated the area hurt so bad she could not sleep the previous night. The resident's recliner was covered with a cloth incontinence pad and did not appear to have a cushion present. Following the cares, Staff C stated to the surveyor she was not exactly sure how long the resident had the area but thought is was approximately 1 week. During an observation on 11/27/18 at 12:30 p.m., the resident sat in a chair at the lunch table with no cushion under her. During an observation on 11/27/18 at 2:30 p.m., the resident sat in her recliner. The recliner did not appear to have a cushion in it. During an observation on 11/28/18 at 8:45 a.m., Staff D CNA assisted the resident to stand up from her recliner as Staff A LPN (Licensed Practical Nurse) measured a red open wound on the resident's right buttock, which measured 1 cm(centimeter) x 1.25 cm with a thin red trail measuring 0.5 cm. Staff D commented the resident had something on her bottom on Monday (11/26/18) when she took care of her, but it was not open at that time. After Staff A measured the area, the resident sat down in the recliner which had a visible, thick black cushion in it. Staff A stated the black cushion was a Roho (a thick cushion used to prevent and treat pressure ulcers) and they took out the "gel one" yesterday	F 686		

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F 686	Continued From page 25 as she pointed to the counter. On the counter was a thin (approximately 1 cm thick) yellow gel cushion. A 9/21/18 9:17 a.m. progress note stated the resident had an open area on the right buttocks approximately 1 cm round, superficial and the resident reported discomfort when sitting. A 9/21/18 9:20 a.m., a progress note listed an order for an Optifoam border dressing (a foam dressing) to the right buttocks applied every other day and as needed. A 10/8/18 9:45 a.m. progress note listed an order to discontinue the Optifoam border dressing and begin Calmoseptine ointment and utilize a Roho cushion in the chair. The progress note lacked any documentation of an assessment of the wound and did not state the area was healed. An 11/3/18 unsigned "Weekly Skin Assessment" had a question marked "yes" for "open cuts, lacerations, lesions, or skin tears" and stated the location was to the right buttocks and the facility discontinued the treatment on 10/8/18. An 11/28/18 10:32 a.m. progress note stated the resident reported pain in the bottom and the nurse faxed the physician regarding an order for a treatment/dressing. The facility lacked any further assessments of the area between the dates of 9/21/18 and 11/28/18 (Wednesday of the survey week). Review of the October TAR (Treatment Administration Record) revealed the resident received Calmoseptine ointment to the buttocks	F 686		

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F 686	Continued From page 26 from 10/8/18-10/21/18. Review of the October and November TARS revealed the facility lacked documentation of a skin treatment to the right buttocks from 10/21/18-11/28/18. 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). 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. 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 regarding measures to prevent skin injury, encourage good nutrition and hydration, and to identify potential causative factors. 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. 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.	F 686		

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F 686	Continued From page 27 The undated facility policy "Identified Skin Concerns" stated the purpose was to provide residents with pressure sores the necessary treatment and services to promote healing, prevent infection, and prevent new sores from development. The policy directed staff to obtain an order for treatment from the physician for each identified skin problem and to complete an assessment weekly. During an interview on 11/28/18 at approximately 10:00 a.m., Staff D stated she took care of the resident in the early morning of 11/26/18 when she helped her get up for the day. She stated at that time the resident had an area on her bottom and the resident told her at that time it was sore. She stated she did not report this to the nurse because she thought the nurses knew about it. She stated the area was not open at the time and it looked worse today because it was currently open. During an interview on 11/28/18 at 12:28 p.m. the DON (Director of Nursing) stated CNAs should report skin concerns to the nurse and the nurse should call the physician to proceed with a treatment. She stated she expected staff to complete skin assessments weekly or every 7-10 days and should utilize a cushion for residents with open wounds. The DON reported she would want the resident's skin conditions and interventions on the care plan.	F 686		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		

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F 689	Continued From page 28 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to implement a safe system with regard to smoking, smoking areas, and smoking safety for 5 of 8 residents identified as independent smokers (Resident #19, #33, #5, #16, #6). The facility had decided to become a smoke free campus, but also had current residents who had admitted to the facility when smoking was permitted and continued to do so. Prior to the time facility banned smoking on the grounds, residents smoked in an enclosed courtyard that allowed staff the opportunity to monitor and provide supervision for them. The facility had assessed residents (via Smoking Safety Screens) to assure they could smoke in a safe manner either by themselves or with supervision, but failed to update the screens regularly or have a system to advise staff regarding which resident could smoke safely on an independent basis. The facility had asked the residents to sign out to leave the facility to smoke, punch in a door code, then walk across a parking lot to a grassy area beyond facility property where a neighbor of the facility gave permission for residents to spoke. The facility maintained the residents were no longer the facility's responsibility when they signed out and smoked in on the lawn area just off campus. The residents kept their own cigarettes and came and went independently to that area when they wished at any time of the day	F 689		

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F 689	Continued From page 29 or night, with no dedicated smoking hours, creating a hazard as a resident could trip in the parking lot in the middle of the evening when with fewer staff in the building. The parking lot also had the potential to become covered with ice. On 11/25/18, 13 inches of snow fell in Washington, IA. The residents then began smoking in an area to side of the front door that contained a table and chairs, because the grassy area was covered with snow piles. The residents were still expected to sign out, although the facility did not have a system in place to monitor which residents were out of the building or how long they had been outside smoking. The facility also lacked a system to check the residents after they had been outside for a period of time to see if they were safe. This constituted an Immediate Jeopardy (IJ) to resident health and safety. The facility reported a census of 37 residents. Findings include: 1. According to the Minimum Data Set assessment tool dated 10/5/18, Resident #19 had diagnoses that included repeated falls, chronic pain, and weakness and had a BIMS (Brief Interview for Mental Status) score as 13 out of 15, that showed the resident demonstrated intact cognitive abilities. The MDS documented the resident required supervision assist for bed mobility, transfers, ambulation (walking), toilet use, and personal hygiene, supervision and set up assistance for dressing and eating, and extensive assistance of 1 staff for bathing. A 10/9/17 12:28 p.m. progress note entry documented staff found the resident lying in the hallway on her back. The resident stated she lost her balance and stumbled going to the sink to get	F 689		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 30 some water. The entry stated the resident complained of right hip and right lower extremity pain. A 12/9/17 4:47 a.m. fall incident note documented staff observed the resident sitting on the floor beside the bed and the resident reported she just slid down the side of the bed and did not hurt herself. A 12/20/17 7:51 a.m. progress note revealed staff found the resident on the floor, but she didn't know how she fell. The note revealed the resident denied pain. A Fall form dated 11/9/18 on 3:45 p.m. progress note entry documented the nurse observed the resident walking back into the building with the DON (Director of Nursing). The nurse documented another resident stated Resident #19 had fallen outside while smoking and he saw her attempting to get up. The nurse described the resident as tearful and complaining of right hip pain. The facility notified the physician and sent the resident to the hospital for evaluation and treatment. An 11/9/18 4:37 p.m. progress note documented the resident returned from the emergency room with a diagnosis of soft tissue contusion (bruise). A 7/20/17 Smoking Safety Screen documented the resident had dropped cigarettes on her clothing at home and assessed the resident as safe to smoke with supervision, but needed the facility to store her lighter and cigarettes. An 11/27/18 Smoking Safety Screen assessed the resident as safe to smoke without	F 689		

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F 689	Continued From page 31 supervision, but needed the facility to store her lighter and cigarettes. The facility lacked an updated Smoking Safety Screen between the dates of 7/20/17 and 11/27/18. Review of the resident's record revealed no screen from the time of the fall on 11/9/18 and 11/27/18, which occurred after the Department representative entered the building on 11/26/18. Care plan entries initiated 5/12/16, documented the resident as at high risk for falls related to a history of falls and narcotic use, with the goal that the resident would be free of injury through the review date. The care plan revealed the resident experienced impaired vision and directed staff to ensure appropriate visual aids glasses available, and also documented she ambulated independently with a walker. The resident's care plan did not address the resident smoking or provide a plan or directive for staff to monitor the resident's safety when she went outside to smoke. Review of the facility sign out log revealed the resident did not sign out of the facility on 11/9/18. During an interview on 11/28/18 at 9:45 a.m., Resident #5 stated he was in the dining room and just happened to look out the window and saw Resident #19's head pop up in view. He stated he could not tell what position she was in but that she was not standing. He immediately reported it to staff and they assisted her. He stated he didn't know what would have happened to the resident had he not looked out the window.	F 689		

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F 689	Continued From page 32 During an interview on 11/28/18 at 10:00 a.m., the resident stated she didn't remember what happened when she fell outside. She stated she ended up with her walker behind her and reported she was outside for perhaps 5-10 minutes. During an interview on 11/28/18 at 11:45 a.m., Staff E LPN (Licensed Practical Nurse) stated she did not give the resident her cigarettes on 11/9/18 before her fall, and reported Staff F was the only other nurse on duty at that time. During an interview on 11/28/18 at 12:13 p.m., Staff F LPN stated she did not give the resident her cigarettes on 11/9/18 before her fall. During an interview on 11/28/18 at 12:30 p.m., the resident stated she kept her cigarettes and a lighter in her coat pocket and then showed the surveyor an almost full pack of cigarettes and a lighter in her pocket. During an interview on 12/3/18 at 1:20 p.m., the DON stated Resident #5 notified her of the resident's fall on 11/9/18 and she went outside to assist the resident inside. The facility provided additional information on 12/5/18 after the surveyors shared findings and exited the building. Included was the following documented statement: on 11/9/18 at approximately 3 - 3:15 p.m. the facility's the facility's Business Office Manager heard a resident enter the code to the front door. She documented she looked to see when someone opened the door to ensure customer service and make a mental note of any residents that exited the building. At that time, she wrote, Resident #19 wore her long tan jacket, had her walker, and was	F 689		

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F 689	Continued From page 33 in good spirits. The statement did not contain any information related to witnessing the fall or a formal or informal plan to check on the resident at a later time or notify staff after a period of time so staff could monitor the resident's whereabouts. 2. The MDS dated 9/3/18, documented Resident # 5 had diagnoses that included non-Alzheimer's dementia, weakness, restlessness, and agitation. The MDS stated the resident required supervision assistance with bed mobility, transfers, walking, and personal hygiene and supervision and setup assistance with eating and bathing. The MDS listed the resident's BIMS score as 14 out of 15, which indicated the resident experienced intact cognition. A Smoking Safety Screen, dated 6/3/17, stated the resident was safe to smoke without supervision and did not need the facility to store his lighter and cigarettes. A Smoking Safety Screen, dated 11/27/18, documented the resident was safe to smoke without supervision, but needed the facility to store his lighter and cigarettes. The facility lacked an updated Smoking Safety Screen between the dates of 6/3/17 and 11/27/18 (the survey week). A care plan entry, dated 8/20/18, documented the facility would complete a smoking assessment quarterly. During an interview on 11/28/18 at 1:08 p.m., the resident stated he kept his cigarettes and lighter in his room and gestured, indicating they were in	F 689		

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F 689	Continued From page 34 his coat pocket currently. 3. According to the MDS dated 11/2/18, Resident #33 had diagnoses that included weakness, schizophrenia, and depression. The MDS revealed the resident required supervision and setup assistance for bed mobility, transfers, walking, dressing, eating, toilet use, and personal hygiene. The MDS documented the resident's BIMS score as 15 out of 15, indicating intact cognition. A Smoking Assessment, dated 6/13/18, stated the resident did not require supervision while smoking and stated the resident needed the facility to store his lighter and cigarettes. A care plan entry, dated 3/3/17, stated the facility stored the resident's smoking supplies at the back nursing station. During an interview on 11/28/18 at 1:10 p.m., the resident stated he kept his cigarettes and lighter in his room and gestured they were in his coat pocket currently. 4. The MDS assessment tool, dated 9/9/18, listed diagnoses for Resident #6 that included heart failure, obesity, and weakness. The MDS stated the resident required supervision and setup assistance with eating and supervision assistance of 1 staff for bathing. The MDS revealed the resident's BIMS score as 15 out of 15, indicating intact cognition. A 6/7/17 Smoking Safety Screen documented the resident as safe to smoke without supervision, but the facility needed to store his cigarettes and lighter with the nurse.	F 689		

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F 689	Continued From page 35 An 11/27/18 Smoking Safety Screen stated the resident was safe to smoke without supervision, but needed the facility to store his cigarettes and lighter. The facility lacked an updated Smoking Safety Screen between the dates of 6/7/17 and 11/27/18 (the survey week). A care plan entry, dated 8/20/18, directed staff to perform a Smoking Safety Screen quarterly. A 3/3/17 entry documented the facility stored the resident's smoking supplies at the back nurses station. During an interview on 11/28/18 at 1:05 p.m., the resident stated he kept his cigarettes and lighter in his room and showed them to the surveyor. 5. According the the MDS dated 10/3/18, Resident #16 had diagnoses that included morbid obesity, weakness, and difficulty walking. The MDS revealed the resident required supervision and set up assistance for bed mobility, transfers, walking, dressing and eating, and extensive assistance of 1 staff for toilet use, personal hygiene, and bathing. The MDS listed the resident's BIMS score as 15 out of 15 indicating intact cognition. A Smoking Safety Screen, dated 8/21/17, revealed Resident #16 required supervision to smoke due to burns noted on her body from smoking at home. The screen also documented the facility had to store her lighter and cigarettes. A Smoking Safety Screen, dated 11/27/18, assessed the resident as safe to smoke without	F 689		

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F 689	Continued From page 36 supervision while the facility stored her lighter and cigarettes. The facility lacked an updated Smoking Safety Screen between the dates of 8/21/17 and 11/27/18 (the survey week). A care plan entry, dated 8/20/18, directed staff to assess safety with smoking independently each quarter. A list the facility provided to the survey team upon entrance on 11/26/18 listed Residents #5, #6, #16 and #33 as independent smokers. The list did not include Resident #19 as an independent smoker. The facility Independent Smoking Policy, dated 11/27/18 directed the facility would keep smoking materials locked in a designated secured location and stated residents would sign themselves out of the facility with nursing staff upon taking possession of the smoking materials. The policy stated nursing staff would check on the the residents every 30 minutes and would increase checks when severe weather dictated. In an interview on 11/27/18 2:30 pm, the corporate nurse consultant acknowledged some of the assessments were not up to date, but staff were updating them. She reported the facility's system directed residents sign out when they went to smoke so they were then outside of the facility's responsibility. In a subsequent interview with the nurse consultant at approximately 3:00 p.m. on the same day, she stated the facility would revise their policy and going forward, the nurse would	F 689		

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F 689	Continued From page 37 keep the sign out book so she will know who went out. The nurse would then check on the residents in 30 minutes. In an interview on 11/28/18 at 5:30 p.m., the Nurse Consultant stated she didn't think the staff really understood the idea of keeping the smoking materials. She stated the nurses would now check to ensure residents returned the cigarettes after coming in from outside. During an interview on 11/27/18 at 3:30 p.m., the Administrator stated the facility stopped using the courtyard area because the facility went "smoke free." She then showed the surveyor the area near the front door with a small patio table and stated this was where the residents smoked currently since the other area was covered with snow. She then showed the surveyor an area at the east end of the parking lot between 2 vehicles that contained piles of snow. The nurse consultant stated it was the neighbor's area and they allowed the residents to smoke there when it was not covered in snow. According to https://www.kcrg.com/content/news/WWC-Snowfall-totals-from-November-25-2018-501251021.html , the town of Washington received 13 inches of snow on 11/25/18. The facility abated the IJ on 11/28/18 by implementing the following actions: 1. All smoking residents to receive smoking safety assessment. (Completed 1/27/18) 2. New BIMS assessment of all smoking residents (Done on 11/28/18) 3. Sweep of resident rooms for smoking materials	F 689		

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F 689	Continued From page 38 that need secured. (11/28/18) 4. Resident's educated regarding smoking protocols. (11/28/18) 5. Residents will be educated regarding the hours of checking out the smoking materials. (11/28/2018) 6. Residents that have signed out to smoke will be checked on by nursing staff after they have been out for 30 min unless severe or inclement weather. 7. Residents that are deemed to be independent smokers will be allowed to smoke per the policy that they have signed. In addition: Audits initiated 11/18/2018 1. Sign in and out sheets for the residents removing smoking materials. 2. Audit of the check on resident safety while smoking.	F 689		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must:	F 868		

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F 868	Continued From page 39 (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation for quarterly Quality Assurance (QA) meetings since last survey and failed to ensure the appropriate number of personnel attended the Quarterly QA Meetings. The facility identified a census of 37 residents. Findings include: 1. At survey entrance, the facility provided the Self-Identified and Correction Form documented on 10/30/18, revealed the new Administrator was unable to locate past QA monthly and/or quarterly data. The facility provided Quality Assurance phone conference forms signed by the consultant, the Registered Nurse and the Physician dated March 16 of 2018 and April 16 2018. The Administrator provided documentation for the Quarterly QA meetings on 10/30/18 and 11/20/18 that revealed the appropriate staff required for the QA meeting had attended. In an interview on 11/28/18 10:55 AM, the Nurse Consultant date of hire 2/20/18 revealed the Administrator had located several sign in sheets. However, the documents lacked dates of the meeting and failed to identify the type of meeting (either quarterly or monthly).	F 868		

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.