STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165344	A. BUILDING _____ B. WING _____	01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT GOWRIE,	1808 MAIN STREET GOWRIE, IA 50543

(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: 2-1-19 The following deficiencies are a result of the annual recertification's survey and investigation of complaint #78877-C completed on January 27-29, 2019. #78877-C substantiated (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C)	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social,	F 561	**F 561** (D) Staff members M.G., L.M. & C.W., as well as other nursing staff have reviewed the Resident's Rights Policy & the Professional Healthcare Staff Guide to knowing & ensuring resident rights documents. Staff M.G., L.M. & C.W., as well as other nursing staff, have been informed of the importance of allowing Resident 21, as well as all residents, to make their own choices in their daily cares, activities, routines, and/or attending meals in the dining room. The D.O.N., or their designee will monitor for compliance. Identified concerns will be brought to QA. This represents my credible allegation of compliance effective **02/01/2019**.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	2/18/19

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.

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F 561	Continued From page 1 religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and resident and staff interviews, the facility failed to ensure 1 of 13 residents given the right to self-determination/choice with preferences for where to eat meals (Resident #21). The facility reported a census of 30 residents. Findings included: 1. A Minimum Data Set (MDS) assessment tool, dated 12/1/18, documented Resident #21 with a Brief Interview for Mental Status (BIMS) score of 11. A score of 8 to 12 indicates moderately impaired cognition. The MDS revealed the resident required supervision with eating and had total dependence on staff for bed mobility, transfers, toilet use, and personal hygiene hygiene. The MDS documented the resident's diagnoses included heart failure, diabetes, muscle weakness and difficulty walking. The resident's care plan directed staff to allow the resident with as much control as possible with preferences for routines and food preferences (start date 11/29/16). Observation on 1/27/19 at 12:30 PM revealed the resident in bed eating the noon meal. When interviewed on 1/27/19 at 1:36 PM the resident stated he had eaten breakfast and lunch in bed today, staff had not asked if he wanted to get up. He reported he liked to eat in room and in dining room and would like to get up and eat in	F 561		

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F 561	Continued From page 2 his wheel chair sometimes. The resident stated staff frequently fail to ask him if he wants to get up for meals. During an interview 1/28/19 at 11:15 AM Staff A, CNA (Certified Nursing Assistant) with ADON (Assistant Director of Nursing) present, verified she had not asked the resident if he wanted to to get up for group exercises scheduled before lunch and planned to leave the resident in bed for lunch since he had a red bottom. Per ADON request, Staff B, CNA, talked to the resident and stated the resident wanted out of bed for lunch.	F 561		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(l)(1)-(7) §483.10(l) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(l)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(l)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		

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F 584	Continued From page 3 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to provide the residents a home like and well maintained shower room. The facility reported a census of 30 residents. Findings included: Observation of the resident's shower room on 1/29/19 at 8:45 AM revealed the following: a. The caulk around the base of the toilet had an orange discoloration that looked like rust. b. The floor 2 inch white tile around the toilet had scattered debris and a cobweb was located in the corner on the floor. c. The grout on the wall beside the shower chair and an orange discoloration similar to rust.	F 584	**F 584 (E)** Pearl Valley Rehab of Gowrie strives to maintain a home like and well maintained facility that includes the shower room. On February 5, 2019 the, a. Caulk around the base of the toilet was cleaned thoroughly to remove any discoloration; b. All debris was removed from around the toilet as well as the cobweb; c. All the grout around the shower chair was thoroughly scrubbed to remove and discoloration; d. Since the whirlpool is not operational, the facility is going to remove it from the shower room, however until that time, all debris in and around the whirlpool will be remain free of debris e. All cob webs from the room have been removed. The Administrator or the Housekeeping Supervisor or their designee, will perform random audits to ensure the shower room is clean & maintained with a home like environment. Identified concerns will be brought to QA for resolution. This represents my credible allegation of compliance effective **02/05/2019.**	

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F 584	Continued From page 4 d. An unused whirlpool tub had debris inside the tub and on the surrounding floor. e. The ceiling and wall above the shower chair had cobwebs. During an interview 1/29/19 at 3:30 PM the Administrator verified the shower room needed general cleaning and acknowledge the ceiling above the shower chair had cracked areas.	F 584		
F 606 SS=E	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Based on review of employee files and staff	F 606	F 606 (E) Pearl Valley Rehab of Gowrie will perform background checks on all new applicants prior to hire to ensure there is no adverse actions against them. A background check was run on Staff C that resulted in Further Research Required and a Rap Sheet was received on 02/01/2019 that showed no additional actions against Staff C since Staff C was cleared by DHS Record Check Evaluation on 04/09/2018. The Administrator spoke with DHS on 02/08/2019 and confirmed that no additional paperwork was necessary if there were no new hits on the Rap Sheet. The Administrator, or their designee, will ensure each new applicant will have a background check completed and the proper clearance to ensure no adverse actions are identified to prevent them in working for this agency. Identified concerns will be brought to QA for resolution. This represents my credible allegation of compliance effective **02/08/2019.**	

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F 606	Continued From page 5 Interview, the facility failed to conduct a criminal or dependent adult abuse background check for all staff prior to hire (Staff C). The facility reported a census of 30 residents. Findings include: 1. A review of employee files revealed the facility hired Staff C as a Certified Nursing Assistant (CNA) on 10/30/18. The record lacked documentation that showed the facility had conducted a criminal or dependent adult abuse background check prior to 10/30/18. During an interview on 1/28/19 at 4:14 PM, the facility Administrator confirmed he did not complete a Single Contact License and Background Check prior to hire (10/30/18) for Staff C, and also verified the record lacked any documentation that indicated anyone at the facility had completed the check. During an interview on 1/29/19 at 8:15 AM, the facility Administrator reported he completed a Single Contact License and Background check for Staff C. The form, dated 1/29/19 showed Staff C not found on the Sex Offender, Child Abuse, or Dependent Adult Abuse Registries. However, the form revealed an inconclusive result for the criminal history that documented further research required and directed the facility to await the Department of Criminal Investigation's final response for the criminal history. The form showed there might be multiple individuals with similar search criteria, requiring more research. The Abuse Prevention, Identification, Investigation, and Reporting Policy with a revision date of 12/18/16 instructed for employee	F 606		

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F 606	Continued From page 6 screening: 1. The facility will conduct an Iowa criminal record check and dependent adult/child abuse registry check on all prospective employees and other individuals engaged to provide services to residents, prior to hire, in the manner prescribed under 481 Iowa's Administrative Code, 58.11(3). The facility will conduct a criminal record check and dependent adult/child abuse registry check on all current employees and other individuals engaged to provide services to residents who have criminal convictions of founded abuse determinations after hire, or where the facility received credible information that an employee has had a criminal convictions or a founded abuse determination subsequent to hire.	F 606		
F 623 SS=C	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.	F 623	F 623 (C) The facilities Ombudsman has been notified of residents 2, 4, and 8 prior discharges from the facility. The facility Administrator, DON, and/or their designee, have reviewed the Regulatory Requirements regarding notification of the facilities Ombudsman regarding residents transferred/discharged from the facility on at least a monthly basis as per Regulatory Guideline 483.15(c)(4)(ii)(D). Identified concerns will be brought to Quality Assurance for resolution. This represents my credible allegation of compliance effective **02/13/2019**.	

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F 623	Continued From page 7 (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or 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	F 623		

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F 623	Continued From page 8 Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual 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 record review and staff interview the facility failed to send a copy of a Notice to	F 623		

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F 623	Continued From page 9 Transfer to a representative of the Office of the State Long Term Care Ombudsman for 4 residents (Resident #11, #14, #8 and #2). The facility reported a census of 30 residents. Findings include: 1. According to the Minimum Data Set with assessment reference date 11/2/18 Resident #11 had a BIMS score of 11, moderately impaired cognitive skills for daily decision making. Resident #11"s clinical record showed the resident had been admitted to the hospital 9/17/18- 9/26/18 and 10/11/18-10/18/8. 2. According to the Minimum Data Set with assessment reference date 11/7/18 Resident #14 had a BIMS score of 13, cognitively intact skills for daily decision making. Resident #14's clinical record showed the resident had been hospitalized 4/18/18-4/22/18, 7/23/18-7/31/18 and 1/24/19. 3. According to the Minimum Data Set with assessment reference date 10/26/18 Resident #8 had a BIMS score of 14, cognitively intact skills for daily decision making. Resident #8's clinical record showed the resident was hospitalized 10/17/18-10/21/18. During interview on 1/29/19 at 8:15 AM the Assistant Director of Nursing (ADON) stated the facility had not been notifying the Ombudsman of discharges to the hospital. 4. A Minimum Data Set (MDS) assessment tool,	F 623		

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F 623	Continued From page 10 dated 9/10/18 documented Resident #2 was transferred to the hospital on 9/10/18. The MDS dated 9/20/18 documented Resident #2 returned to the facility from the hospital. Resident #2's medical record lacked documentation the Ombudsman had been notified of the resident's transfer. During an interview 1/29/19 at 9:30 AM the Administrator verified the Ombudsman had not been notified of the resident's transfer.	F 623		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for	F 625		

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F 625	Continued From page 11	F 625		

hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to notify a resident and/or the residents representative of the facility policy for bed hold prior to transfer to a hospital or within 24 hours after admitted to a hospital for 4 residents, (Resident #11, #14, #8 and #2). The facility reported a census of 30 residents.

Findings include:

1. According to the Minimum Data Set with assessment reference date 11/2/18 Resident #11 had a BIMS score of 11, moderately impaired cognitive skills for daily decision making.

Resident #11's clinical record showed the resident had been admitted to the hospital 9/17/18- 9/26/18 and 10/11/18-10/18/8. The clinical record lacked documentation of bed hold notice provided to the resident or resident representative for either hospitalization.

2. According to the Minimum Data Set with assessment reference date 11/7/18 Resident #14 had a BIMS score of 13, cognitively intact skills for daily decision making.

Resident #14's clinical record showed the resident had been hospitalized 4/18/18-4/22/18, 7/23/18-7/31/18 and 1/24/19. The record lacked documentation the resident or resident representative had received notification of bed

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(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 625	Continued From page 12 hold. 3. According to the Minimum Data Set with assessment reference date 10/26/18 Resident #8 had a BIMS score of 14, cognitively intact skills for daily decision making. Resident #8's clinical record showed the resident was hospitalized 10/17/18-10/21/18. The record lacked documentation the resident or resident representative had been giving notification of bed hold. During interview on 1/29/19 at 8:15 AM the Assistant Director of Nursing (ADON) stated the facility had not been giving residents or resident representative notification of bed hold when admitted to the hospital. 4. A Minimum Data Set (MDS) assessment tool, dated 9/10/18 documented Resident #2 was transferred to the hospital on 9/10/18. An MDS, dated, 9/20/18 documented Resident #2 returned to the facility from the hospital. Resident #2's medical record lacked documentation the facility provided a bed hold notice to the resident or resident's representative. During an interview 1/29/19 at 8:15 AM the DON (Director of Nursing) verified a bed hold notice was not given to the resident or resident's representative.	F 625	**F 625** (C) The DON, their designee, as well as facility Nurses have reviewed the Regulatory Requirements (483.15) regarding the Notice of Bed-Hold Policy and Return. The Facility has implemented the Bed-Hold Policy and instructed the Nurses to try to ensure this document is addressed with the resident, as well as the resident's representative prior to the residents discharge/transfer from the facility, or addressed with the residents representative as soon as possible following the residents discharge/transfer from the facility. The DON, or their designee, will monitor that this practice of Bed-Hold notification is completed. Identified concerns to Quality Assurance for resolution. This represents my credible allegation of compliance effective **02/01/2019**.	
F 655 SS=C	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care	F 655		

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	165344	A. BUILDING _____ B. WING _____	01/29/2019

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F 655	Continued From page 13 Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting	F 655		

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F 655	Continued From page 14 on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to complete baseline care plans within 48 hours after admission for two (2) residents, (Resident #14, and #8). The facility reported a census of 30 residents. Findings include: 1. Review of Resident #14's clinical record showed the resident had been admitted to the facility on 3/13/18. The record lacked a baseline care plan. 2. Review of Resident #8's clinical record showed the resident had been admitted 1/8/18. The record lacked a baseline care plan. During interview on 1/29/19 at 9:20 AM the Assistant Director of Nursing stated she was unable to find a Baseline Care Plan completed for Resident #14 and Resident #8.	F 655	**F 655** (C) The DON, and their designee, have reviewed and been informed of the importance of complying with the Regulatory Requirements (483.21) regarding the Development of Baseline Care Plans within 48 hours of a resident's admission. Comprehensive Care Plans have been developed and implemented for Resident 14 (expired 02/05/2019) and Resident 8. The D.O.N., or their designee, will conduct random audits and bring identified issues to QA. This represents my credible allegation of compliance effective **02/01/2019**	
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 clinical record review and staff interview, the facility failed to follow physician	F 658	**F 658** (D) The facility has contacted Resident #27's Pharmacy to inform them of the necessity to have them include Physician ordered parameters for holding beta blocker medications on his, or any residents, MAR. For those residents who receive beta blocker medications and use a cont.....	

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F 658	Continued From page 15 orders for 1 of 16 residents reviewed (Resident #27). The facility reported a census of 30 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 12/23/18 Resident #27 had diagnoses that included, Hypertension, Peripheral Vascular disease and depression. The MDS identified the resident with a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired decision making abilities, and required limited assistance with dressing, toilet use and supervision with eating. The Physician Order signed and dated on 12/11/18 instructed staff to administer Metoprolol Tart, 100 milligrams. Give one tablet by mouth twice a time a day related to hypertension. Hold all Beta Blocker Medication if pulse less than 60, or systolic blood pressure less than 110. Review of the Medication Administration Record (MAR) for 11/1/18-11/30/18, The Medication Administration Record failed to include the daily pulse and blood pressures. Review of the Weight and Vitals Flow sheet dated 11/28/18, documented vitals completed on 11/28/18 and only weight for 12/1/18 and 1/5/19. Review of the Skilled Daily Nursing Notes on these dates documented the residents pulse: 12/3/18 at 52 12/8/18 at 54 12/12/18 at 52 12/13/18 at 50 12/14/18 at 52	F 658	**F 658 (D)** The facility has contacted Resident #27's Pharmacy to inform them of the necessity to have them include Physician ordered parameters for holding beta blocker medications on his, or any residents, MAR. For those residents who receive beta blocker medications and use a different Pharmacy the facility has attempted to ensure that Physician approved parameters for holding beta blocker medications are noted on those residents MAR's. The facility Nurses reviewed the Administration of Medication Policy and have been informed of the importance of obtaining resident #27's, or any other resident receiving beta blocker medications, pulse and blood pressure to confirm the residents pulse and blood pressure are within the Physician ordered parameters for administration of the medication. The DON, or their designee, will perform random audits and bring any identified concerns to Quality Assurance. This represents my credible allegation of compliance effective **02/08/2019**	

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F 658	Continued From page 16 12/15/18 at 58 12/16/18 at 54 for the day shift and 54 for the night shift 12/22/18 at 54 12/23/18 at 56 Review of the MAR for 1/1/19-1/31/19, the Medication Administration Record failed to include the daily pulse and blood pressures. During an interview on 1/29/19 at 10:05 a,m,. the facility director of nursing confirmed and verified that the MAR failed to address the blood pressure and pulses and that the expectation of the nurses is to follow the physicians orders as written. During an interview on 1/29/19 at 1:18 p.m., the facility corporate quality assurance nurse confirmed and verified that the pulse and blood pressures were not on the MAR and that the expectation is for the nurses to follow the physicians orders.	F 658	different Pharmacy the facility has attempted to ensure that Physician approved parameters for holding beta blocker medications are noted on those residents MAR's. The facility Nurses reviewed the Administration of Medication Policy and have been informed of the importance of obtaining resident #27's, or any other resident receiving beta blocker medications, pulse and blood pressure to confirm the residents pulse and blood pressure are within the Physician ordered parameters for administration of the medication. The DON, or their designee, will perform random audits and bring any identified concerns to Quality Assurance. This represents my credible allegation of compliance effective **02/08/2019**	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review the facility failed to provide complete and proper incontinence care for 1 of 3 residents reviewed who were incontinent (Resident #84). and the facility failed to assist 2 of 13 active residents reviewed with oral hygiene on a regular basis	F 677		

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F 677	Continued From page 17 (Residents #21 and #183). The facility reported a census of 30 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment with a reference dated of 1/22/19 Resident #84 had diagnoses that included anemia, hypertension, asthma, nontraumatic subarachnoid hemorrhage, and limitation of activities due to disability. The MDS documented the resident with short and long term memory impairments and severely impaired in decision making abilities, and required total assistance with all aspects of daily living. The MDS assessment documented the resident as always incontinent of bladder and bowel. The Baseline care plan with an admit date of 1/15/19 stated incontinent of bowel and bladder with peri cares done by the staff. During an observation on 1/28/19 at 8:12 AM Staff A and Staff B (Certified Nursing Assistants) proceeded to provide incontinency cares on the resident. Staff A cleansed the resident's left and right groin and then middle of peri area, Staff A and Staff B then position the resident on the right side, Staff A cleansed the residents left hip and buttock area with wet wipes, then proceeded to cleanse from back to front on the resident coccyx area to the peri area. During an interview on 1/29/19 at 9:30 AM the facility DON confirmed Staff A needed to cleanse the peri area and coccyx area from front to back. Incontinence Care Protocol with a revision dated 10/26/15, instructed staff to:	F 677	**F 677** (D) Nursing Staff A's employment was terminated effective 1-29-19. Staff B, as well as all Nursing staff, have reviewed the Incontinence Care Protocol and been informed of the importance of performing incontinence care as per facility protocol for Resident #84, and any other dependent Resident. Nursing Staff B, as well as all Nursing Staff have reviewed the Oral Hygiene, Oral Hygiene for the Unconscious Resident, and the Mouth Care of Edentulous Resident Protocols and have been informed of the importance of assisting or providing residents #21 and #183, as well as all Residents,with oral hygiene as per facility protocol. Nursing staff, including Staff B, have been informed that failure to provide appropriate care to Residents #21, #84, and #183, or any other resident, may result in disciplinary actions up to and including termination. The DON, or their designee, will perform random audits and bring any identified concerns to Quality Assurance. This represents my credible allegation of compliance effective **02/01/2019**	

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F 677	Continued From page 18 #10. Women-gently separate genitalia wash down one side, then the other making sure to wash Front to Back. Turn the cloth surface with each wipe and dry. 2. A Minimum Data Set (MDS) assessment tool dated 12/1/18 documented Resident #21 with a Brief Interview for Mental Status (BIMS) score of 11. A score of 8 to 12 indicates moderately impaired cognition. The MDS revealed the resident had total dependence on staff for bed mobility, transfers, toilet use, and personal hygiene hygiene, including brushing teeth. The MDS documented the resident's diagnoses included heart failure, diabetes, muscle weakness and difficulty walking. The resident's care plan with a revision date of 12/13/17 documented the resident required staff assistance with activities of daily living due to weakness and decreased mobility. During an interview 1/27/19 at 1:55 PM the resident stated he had his own teeth and the staff had not helped him brush his teeth for awhile. During an interview with the DON (Director of Nursing) and ADON (Assistant Director of Nursing) present on 1/28/19 at 11:15 AM Staff A and Staff B, CNA's stated they had not helped the resident brush their teeth this morning during cares. During an interview 1/28/19 at 11:15 AM the ADON stated she expected staff to assist resident's with oral hygiene with daily cares. 3. An Initial Nursing Assessment documented Resident #183 was admitted to the facility on	F 677		

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F 677	Continued From page 19 1/23/19. The assessment documented the resident's memory intact, alert, and oriented to season, places, names, and faces, and family reported the resident possibly confused with hallucinations at night. When interviewed on 1/28/19 at 8:53 AM the resident stated staff had not offered assistance with brushing her teeth since admission. She reported she normally brushed her teeth daily and would like her teeth brushed. She stated a family member planned to bring her a tooth brush and tooth paste. During an interview 1/28/19 at 11:18 AM Staff A, CNA stated she helped the resident get out of bed today and transported the resident directly to the shower without assisting her with oral hygiene. During an interview 1/28/19 at 11:18 AM the DON and ADON obtained a tooth brush and tooth paste and directed Staff A to help the resident with brushing her teeth immediately.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §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.	F 679	F 679 (D) AD is now personally and has directed her Activity Asst. to bring Resident 21 out to those group activities of his choice and document refusals. The AD will continue 1 on 1's; developing an acceptable 1 on 1 program for each resident to meet their individual needs. The AD, or their designee, will bring any identified concerns to Quality Assurance. This represents my credible allegation of compliance effective **02/08/2019**	

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F 679	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interview, the facility failed to ensure 1 of 13 residents received an ongoing activity program of choice (Resident #21). The facility reported a census of 30 residents. Findings include: 1. A Minimum Data Set (MDS) assessment tool dated 12/1/18 documented Resident #21 with a Brief Interview for Mental Status (BIMS) score of 11. A score of 8 to 12 indicates moderately impaired cognition. The MDS revealed the resident required supervision with eating and had total dependence on staff for bed mobility, transfers, toilet use, and personal hygiene hygiene. The MDS documented the resident's diagnoses included heart failure, diabetes, muscle weakness and difficulty walking. The MDS revealed the resident felt it was very important to have books, newspapers, and magazines to read and keep up with the news and not important at all to be with groups of people. The resident's Activities care plan directed staff to allow the resident to make choices, choose between a shower and a tub, bath, go outside when nice encourage involvement with Bingo, church services, and so on, and report signs of isolation (last review date 12/1/18). The care plan lacked documentation of any one to one activities and any activities brought to the room for the resident. The resident's December 2018 and January 2019 activity sheets revealed the resident frequently	F 679		

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F 679	Continued From page 21 attended coffee/tea and chatter, socializing, and watched television. The January 2019 activity schedule revealed Bingo scheduled on 1/29/19 at 2:00 PM. Observation 1/29/19 at 2:52 PM revealed Bingo activity in the dining room and Resident #21 not present. During an interview on 1/29/19 at 4:00 PM the AD stated the resident was on the bed pan when she asked if he wanted to attend Bingo.	F 679		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide eight (8) consecutive hours of Registered Nurse, RN, coverage seven (7) day a week. The facility reported a census of 30 residents. Findings include:	F 727	F 727 (E) The DON, and/or their designee, have reviewed the Regulatory Requirements (483.35(b) and 483.5(b)(1) regarding the necessity of RN coverage for at least 8 consecutive hours a day, 7 days a week. The DON, or their designee will ensure compliance with this Regulatory Requirement. The DON, or their designee, will perform random audits and bring any identified concerns to Quality Assurance. This represents my credible allegation of compliance effective **02/04/2019**	

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F 727	Continued From page 22 Review of the schedules December 16, 2018 through January 27, 2019, revealed no RN scheduled to work on: 1. Saturday, December 22, 2018 2. Sunday, December 23, 2018 3. Thursday, January 1, 2019 4. Saturday, January 5, 2019 5. Saturday, January 19, 2019 6. Friday, January 26, 2019 During an interview on 1/29/19 at 8:30 AM the facility DON (Director of Nursing) stated that they were not aware of the regulation that required eight (8) hours of RN coverage daily and that he/she would be working more hours. During an interview on 1/29/19 at 10:31 AM the facility corporate quality assurance nurse confirmed there was no RN scheduled or coverage on the days and dates listed above. The DON confirmed that the facility needed to have an RN scheduled on every day of the week.	F 727		
F 729 SS=E	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency	F 729		

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PEARL VALLEY REHABILITATION AND NURSING AT GOWRIE,	1808 MAIN STREET GOWRIE, IA 50543

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F 729	Continued From page 23 evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on review of employee files and staff interview the facility failed to assure all nursing assistants were listed on the Nurse Aide Registry prior to hire (Staff C). The facility reported a census of 30 residents. Findings included: 1. A review of employee files revealed the facility hired Staff C as a Certified Nursing Assistant (CNA) on 10/30/18. The record lacked documentation that showed the facility had verified the nursing assistant's training and registration on the Nurse Aide Registry prior to hire.	F 729	F 729 (E) The Facility Administrator verified Staff C's CNA Registration on 1-29-19. The Facility Administrator completed a Single Contact License and Background Check for Staff C on 01-29-19. On 02-13-19 the Administratorcontacted DHS pertaining to a Record Check Evaluation regarding Staff C's employment status and was informed that based on the 01-29-19 DCI report indicating no further criminal charges being listed on the Criminal History Rap Sheet since the prior back ground In March of 2018 from which DHS cleared April 9, 2018 for Staff C to work for this Agency and stated since there were no new hits on the Rap Sheet, this employee would be approved to be employed in a LTC setting. The Administrator/DON, or their designee, have reviewed the Regulatory Requirements (483.12) regarding performing criminal background checks and the Regulatory Requirements (483.35(d)(4) regarding CNA Registry verification checks prior to offering employment to Staff C, or any other applicants. The Administrator, DON, or their designee, will confirm the completion of the Single Contact License and Background Check and CNA Registry / Staff Licensure prior to applicants being offered employment. .....cont.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165344	A. BUILDING _____ B. WING _____	01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 729	Continued From page 24 During an interview on 1/28/19 at 4:14 PM, the facility Administrator confirmed he did not complete a Single Contact License and Background Check prior to hire (10/30/18) for Staff C, and verified the record lacked any documentation that indicated anyone at the facility completed it. During an interview on 1/29/19 at 8:15 AM, the facility Administrator reported he completed a Single Contact License and Background check for Staff C. The form, dated 1/29/19, contained documentation that verified the CNA's name was on the Nurse Aide Registry in good standing.	F 729	Any ongoing concerns will be addressed with the QA Committee. This represents my credible allegation of compliance effective **02/01/2019**	