## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/11/2019 FORM APPROVED

CORRECTION ROVIDER OR SUPPLIER LLLEY REHABILITATION A SUMMARY STATE (EACH DEFIDIENCY M REQULATORY OR LSC INITIAL COMMENTS Correction date:	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165344 ND NURSING AT GOWRIE, EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	180		COMPLET
SUMMARY STATE (EACH DEFIDIENCY M REQULATORY OR LSC INITIAL COMMENTS Correction date: 2-1.	ND NURSING AT GOWRIE, EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	8 MAIN STREET WRIE, IA 50543 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	Ke) COMPLET
SUMMARY STATE (EACH DEFIDIENCY M REQULATORY OR LSC INITIAL COMMENTS Correction date: 2-1.	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	IB0 ID PREFIX TAG	8 MAIN STREET WRIE, IA 50543 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	Ke) COMPLET
SUMMARY STATE (EACH DEFIDIENCY M REQULATORY OR LSC INITIAL COMMENTS Correction date: <u>2-1</u> . The following deficiencie	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	WRIE, IA 50543 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	COMPLET
SUMMARY STATE (EACH DEFIDIENCY M REQULATORY OR LSC INITIAL COMMENTS Correction date: <u>2-1</u> . The following deficiencie	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	COMPLET
(EACH DEFICIENCY N REQULATORY OR LSC INITIAL COMMENTS Correction date: $2 - 1$ . The following deficiencie	NUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	COMPLET
Correction date: <u>2-1</u>	-18	F 000		
The following deficiencie	-18			
annual recertification's s	es are a result of the			
	urvey and investigation of			
complaint #78877-C con	npleted on January			
27-29, 2019. #78877-C substantlated				
	equiations (42CFR) Part			
483, Subpart B-C)				
Self-Determination		F 561		
CFR(s): 483.10(f)(1)-(3)(	8)			
The resident has the righ promote and facilitate res hrough support of reside not limited to the rights sp 1) through (11) of this se (483.10(f)(1) The resider totivities, schedules (incli- vaking times), health car- are services consistent v assessments, and plan of pplicable provisions of the tacility that are significant 483.10(f)(2) The residen holces about aspects of acility that are significant 483.10(f)(3) The residen the members of the com- ommunity activities both noility.	t to and the facility must sident self-determination int choice, including but becified in paragraphs (f) bection. In thas a right to choose uding sleeping and e and providers of health with his or her interests, f care and other his part. It has a right to make his or her life in the to the resident. It has a right to interact munity and participate in inside and outside the		<ul> <li>F 301 (D)</li> <li>Staff members M.G., L.M. &amp; C.W well as other nursing staff have reviewed the Resident's Rights Po &amp; the Professional Healthcare Sta Guide to knowing &amp; ensuring resirights documents. Staff M.G., L.I C.W., as well as other nursing stathave been informed of the import of allowing Resident 21, as well a residents, to make their own choic their daily cares, activities, routine and/or attending meals in the dinit room. The D.O.N., or their design will monitor for compliance. Identified concerns will be brough QA.</li> <li>This represents my credible allege of compliance effective 02/01/201</li> </ul>	blicy ff ident M. & ff, ance is all ces in es, ng nee nt to
	(See Code of Federal Re (883, Subpart B-C) Self-Determination CFR(s): 483.10(f)(1)-(3)( (483.10(f) Self-determination (The resident has the right) promote and facilitate rest hrough support of resider inter and facilitate rest hrough support of resider (1) through (11) of this set (483.10(f)(1) The resider (1) through (11) of this set (483.10(f)(1) The resider (1) through (11) of this set (483.10(f)(2) The resider (1) the set of the composition of the (1) through (11) of the set (1) through (11) of this set (483.10(f)(2) The resider (1) the set of the composition of the (1) the set of the composition of the composition of the composition (1) the set of the composition of the composition of the composition (1) the set of the composition of the composition of the composition of the composition of the composition (1) the set of the composition of the composition of the composition (1) the set of the composition of	See Code of Federal Regulations (42CFR) Part 483, Subpart B-C) 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 hrough 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 citivities, schedules (including sleeping and vaking times), health care and providers of health are services consistent with his or her interests, ssessments, and plan of care and other pplicable provisions of this part. 483.10(f)(2) The resident has a right to make holces about aspects of his or her life in the actility that are significant to the resident. 483.10(f)(3) The resident has a right to interact ith members of the community and participate in pommunity activities both inside and outside the	See Code of Federal Regulations (42CFR) Part         483, Subpart B-C)         Self-Determination         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         hrough 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         ctivities, schedules (including sleeping and         vaking times), health care and providers of health         are services consistent with his or her interests,         ssessments, and plan of care and other         pplicable provisions of this part.         483.10(f)(2) The resident has a right to make         holces about aspects of his or her life in the         uclity that are significant to the resident.         483.10(f)(3) The resident has a right to interact         ith members of the community and particlpate in         ormunity activities both inside and outside the         cility.         483.10(f)(8) The resident has a right to         and outside the         cility.	(See Code of Federal Regulations (42CFR) Part 483, Subpart B-C)       F 561         (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C)       F 561         Self-Determination       F 561         CFR(s): 483.10(f) (J)-(3)(8)       F 561         (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C)       F 561         (See Code of Federal Regulations (42CFR) Part 483, 10(f)(J)-(3)(8)       F 561         (See Code of Federal Regulations (42CFR) Part 483, 10(f)(1)-(3)(8)       F 561         (See Code of Federal Regulations (42CFR) Part 483, 10(f)(2) The resident has a right to choose clivities, schedules (including steping and taxe been informed of the import of allowing Resident 21, as well as clivities, schedules (including steping and taxe been informed of the import of allowing Resident 21, as well as residents, to make their own choit their daily cares, activities, routint and/or attending meals in the dini room. The D.O.N., or their design will monitor for compliance. Identified concerns will be brough QA.         483,10(f)(2) The resident has a right to make holces about aspects of his or her life in the culity.       This represents my credible allege of compliance effective 02/01/201         483,10(f)(8) The resident has a right to articipate in other activities, including social,       This represents my credible allege of compliance effective 02/01/201

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.

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

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PRINTED: 02/11/2019

FORM APPROVED OMB NO. 0938-0391

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	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		165344	B. WING		01/29/2019	
	Rovider or Supplier	AND NURSING AT GOWRIE,	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 MAIN STREET GOWRIE, IA 50543			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	jd Prefjx Tag	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
	Interfere with the right facility. This REQUIREMENT by: Based on record revi- resident and staff inte ensure 1 of 13 resides self-determination/ohd where to eat meals (R reported a census of 3 Findings included: 1. A Minimum Data Se dated 12/1/18, docum Brief Interview for Mer 11. A score of 8 to 12 Impaired cognition. The resident required supe- total dependence on s transfers, toilet use, ar hygiene. The MDS doo diagnoses included he muscle weakness and The resident's care pla- resident with as much preferences for routine (start date 11/29/16). Observation on 1/27/11 resident in bed eating When interviewed on 1 resident stated he had in bed today, staff had get up. He reported he	nity activities that do not ts of other residents in the is not met as evidenced ew, observation, and rviews, the facility failed to ints given the right to olce with preferences for tesident #21). The facility 30 residents. et (MDS) assessment tool, ented Resident #21 with a that Status (BIMS) score of indicates moderately e MDS revealed the ervision with eating and had taff for bed mobility, nd personal hygiene cumented the resident's eart failure, diabetes, difficulty walking. an directed staff to allow the control as possible with es and food preferences 9 at 12:30 PM revealed the the noon meal.	F 561			

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Event ID: FX9511

Facility ID: 1A0117

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		ID HUMAN SERVICES		، 	FOR	ED: 02/11/2019 MAPPROVED O, 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		e survey Pleted	
		165344	B, WING		01	/29/2019
	ROVIDER OR SUPPLIER ALLEY REHABILITATION	AND NURSING AT GOWRIE,	180	REET ADDRESS, CITY, STATE, ZIP CO 18 Main Street 19 Wrie, 14 50543		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFIGIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X6) COMPLETION DATE
	staff frequently fall to up for meals. During an interview 1/ CNA (Certified Nursin (Assistant Director of is she had not asked the get up for group exerce lunch and planned to i lunch since he had a r request, Staff B, CNA, stated the resident wa Safe/Clean/Comfortab CFR(s): 483.10(l)(1)-(1) §483.10(l) Safe Enviro The resident has a rigit comfortable and home but not limited to receil supports for daily living The facility must provid §483.10(i)(1) A safe, c homelike environment use his or her persona possible. (i) This includes ensuri receive care and servit physical layout of the f independence and doe (ii) The facility shall exercise	imes. The resident stated ask him if he wants to get 28/19 at 11:15 AM Staff A, g Assistant) with ADON Nursing) present, verified resident if he wanted to to ises scheduled before eave the resident in bed for ed bottom. Per ADON talked to the resident and nted out of bed for lunch. Ne/Homeilke Environment 7) inment. to a safe, clean, like environment, including ving treatment and g safely. de- lean, comfortable, and allowing the resident to belongings to the extent ng that the resident can	F 584			
	§483.10(i)(2) Houseke	eping and maintenance maintain a sanitary, orderly, r;			>	-

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

Facility ID: IA0117

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TATEMENT	RS FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	
ND PLAN O	ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	,	COMPLETED	
		165344	B. WING		01/29/20	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL V	ALLEY REHABILITATION	AND NURSING AT GOWRIE,		BOS MAIN STREET		
			<b>E</b>	OWRIE, IA 50543		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE COMP	
	<ul> <li>§483.10(I)(3) Clean be in good condition;</li> <li>§483.10(I)(4) Private of resident room, as spect §483.10(I)(5) Adequate levels in all areas;</li> <li>§483.10(I)(6) Comfortate levels. Facilities initially 1990 must maintain at 81°F; and</li> <li>§483.10(I)(7) For the mission of the resist This REQUIREMENT by:</li> <li>Based on observation facility falled to provide and well maintained shift reported a census of 3</li> <li>Findings included;</li> <li>Observation of the resist 1/29/19 at 8:45 AM revisit</li> <li>a. The caulk around the orange discoloration the b. The floor 2 linch whitt scattered debris and a corner on the floor.</li> </ul>	ed and bath linens that are closet space in each cified in §483.90 (e)(2)(lv); e and comfortable lighting able and safe temperature y certified after October 1, temperature range of 71 to naintenance of comfortable is not met as evidenced and record review, the the residents a home like ower room. The facility 0 residents. dent's shower room on ealed the following: e base of the toilet had an at looked like rust. e tile around the toilet had cobweb was located in the	F 584	<ul> <li>F 584 (E)</li> <li>Pearl Valley Rehab of Gowrle str maintain a home like and well maintained facility that includes t shower room. On February 5, 20</li> <li>a. Caulk around the base of the was cleaned thoroughly to re any discoloration;</li> <li>b. All debris was removed from around the toilet as well as th cobweb;</li> <li>c. All the grout around the show chair was thoroughly scrubbe remove and discoloration;</li> <li>d. Since the whirlpool is not operational, the facility is goi remove it from the shower ro however until that time, all de in and around the whirlpool v remain free of debris</li> <li>e. All cob webs from the room 1 been removed.</li> <li>The Administrator or the Housekee Supervisor or their designee, will perform random audits to ensure t shower room is clean &amp; maintaine with a home like environment. Identified concerns will be brough QA for resolution,</li> <li>This represents my credible allega of compliance effective 02/05/201</li> </ul>	he 19 the, toilet move we ver ed to ng to om, ebris vill be have eeping he ed at to tion	

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	MENT OF HEALTH AN	ID HUMAN SERVICES			PRINTED: 02/11/2019 FORM APPROVED OMB NO: 0938-0391
	of Deficiencies F Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED
		165344	B. WING		01/29/2019
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
PEARL V	ALLEY REHABILITATION	AND NURSING AT GOWRIE,		08 MAIN STREET OWRIE, IA 50543	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	E Abort
F 584	d. An unused whirlpoo tub and on the surrou	of tub had debris inside the	F 584		
	general cleaning and a above the shower cha	the shower room needed acknowledge the celling ir had cracked areas. taff w/ Adverse Actlons	F 606	F 606 (E) Pearl Valley Rehab of Gowrie will	
	Individuals who- (I) Have been found guesploitation, misappro- mistreatment by a cour (II) Have had a finding nurse aide registry cor exploitation, mistreatm misappropriation of the (III) Have a disciplinary or her professional fice body as a result of a fil exploitation, mistreatm misappropriation of res §483.12(a)(4) Report to registry or licensing au has of actions by a con- employee, which woul- service as a nurse aide This REQUIREMENT by:	bloy or otherwise engage uilty of abuse, neglect, priation of property, or rt of law; entered Into the State neerning abuse, neglect, nent of residents or ear property; or v action in effect against his ense by a state licensure nding of abuse, neglect, nent of residents or sident property. to the State nurse alde ithorities any knowledge it urt of law against an d indicate unfitness for		<ul> <li>perform background checks on all mapplicants prior to hire to ensure the no adverse actions against them. A background check was run on Staff that resulted in Further Research Required and a Rap Sheet was receiption 02/01/2019 that showed no additional actions against Staff C sin 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 there were no new hits on the Rap Sheet. The Administrator, or their designee, will ensure each new applicant will have a background check generation and the proper clearance ensure no adverse actions are identit to prevent them in working for this agency. Identified concerns will be brought to QA for resolution.</li> </ul>	re is C Ved noce I Che I Che I Che I Che I Che I Che I Che I On

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Facility ID: IA0117

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		ND HUMAN SERVICES MEDICAID SERVICES				INTED: 02/11/201 FORM APPROVE I <u>B NO, 0938-039</u>
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		165344	B. WING			01/29/2019
	ROVIDER OR SUPPLIER	AND NURSING AT GOWRIE,		STREET ADDRESS, CITY, STATE, ZIP C 1808 MAIN STREET GOWRIE, IA 50543	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENGED TO T DEFICIENC	ION SHOULD BE He Appropriate	(X6) COMPLETION DATE
	Interview, the facility f or dependent adult at all staff prior to hire (S a census of 30 residen Findings include: 1. A review of employed hired Staff C as a Cerr (CNA) on 10/30/18. The documentation that she conducted a criminal of background check prior During an Interview or facility Administrator of complete a Single Corr Background Check prior Staff C, and also verified documentation that Interview on facility had completed During an Interview on facility had completed During an Interview on facility Administrator re Single Contact License for Staff C. The form, of C not found on the Sex Dependent Adult Abusiform revealed an incorr criminal history that do required and directed to Department of Crimina response for the crimina	ailed to conduct a criminal puse background check for itaff C). The facility reported ints. The facility reported ints. The facility reported ints. The facility reported ints. The record lacked owed the facility had or dependent adult abuse or to 10/30/18. The record lacked abuse or to 10/30/18. The record lacked any licated anyone at the the check. The check licated anyone at the the check. The record lacked any licated anyone at the the check. The check lated the completed a a and Background check lated the result for the cumented further research the facility to await the I Investigation's final	F 6	06		
	The Abuse Prevention,	Identification, orting Policy with a revision				

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Facility ID: IA0117

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			an e		FORM APPROVED OMB NO, 0938-0391
STATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CC IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED
	165344		B, WING	01/29/2019	
NAME OF PROVIDER OR SUPPLIER PEARL VALLEY REHABILITATION AND NURSING AT GOWRIE,			11	TREET ADDRESS, CITY, STATE, ZIP CODE 808 MAIN STREET COWRIE, IA 50543	
(X4) JD PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
SS=C	check and dependent check on all prospecti individuals engaged to residents, prior to hire under 481 Iowa's Adm The facility will conduc and dependent adult/o on all current employe engaged to provide se have criminal conviction determinations after h received credible infor has had a criminal corr abuse determination s Notice Requirements i CFR(s): 483.15(c)(3)-( §483.15(c)(3) Notice to Before a facility transfer resident, the facility m (i) Notify the resident a representative(s) of th the reasons for the mo- language and manner facility must send a co representative of the C Long-Term Care Ombi- (li) Record the reasons discharge in the reside accordance with parag-	duct an lowa criminal record adult/child abuse registry ve employees and other o provide services to , in the manner prescribed hinistrative Code, 58.11(3). et a criminal record check shild abuse registry check bes and other individuals protes to residents who ons of founded abuse ire, or where the facility mation that an employee hylotions or a founded ubsequent to hire. Before Transfer/Discharge (6)(8) before transfer. ers or discharges a ust- and the resident's e transfer or discharge and ove in writing and in a they understand. The py of the notice to a Diffice of the State udsman. s for the transfer or ent's medical record in graph (c)(2) of this section; we the items described in	F 606	F 623 (C) The facilities Ombudsman has been notified of residents 2, 4, and 8 pri- discharges from the facility. The facility Administrator, DON, and/c their designee, have reviewed the Regulatory Requirements regarding notification of the facilities Ombudsman regarding residents transferred/discharged from the fac on at least a monthly basis as per Regulatory Guideline 483.15(c)(4)(ii)(D). Identified con will be brought to Quality Assuran for resolution. This represents my credible allegat	or r g ility cerns ce
	§483.15(c)(4) Timing c			of compliance effective 02/13/2019	

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PRINTED: 02/11/2019

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/11/20 FORM APPROVE OMB NO, 0938-039
ITATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
		165344	B, WING		01/29/2019
	ROVIDER OR SUPPLIER	AND NURSING AT GOWRIE,	1808	EET ADDRESS, CITY, STATE, ZIP CODE MAIN STREET VRIE, IA 50543	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
	<ul> <li>(i) Except as specified</li> <li>(c)(8) of this section, discharge required ur made by the facility a resident is transferred</li> <li>(ii) Notice must be mabelore transfer or disc</li> <li>(iii) Notice must be mabelore transfer or disc</li> <li>(A) The safety of individe endangered under this section;</li> <li>(B) The health of individe endangered, under this section;</li> <li>(C) The resident's health of endangered, under this section;</li> <li>(C) The resident's health of endangered, under this section;</li> <li>(C) The resident's health of endangered, under this section;</li> <li>(C) The resident's health of endangered, under paragraph (c)(1</li> <li>(D) An immediate transferred by the reside under paragraph (c)(1</li> <li>(E) A resident has not days.</li> <li>§483.15(c)(5) Content notice specified in paramust include the follow</li> <li>(ii) The effective date of (iii) The location to what transferred or discharge (iv) A statement of the including the name, and and telephone number receives such requests to obtain an appeal for completing the form ar hearing request;</li> </ul>	d in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be t least 30 days before the d or discharged, ade as soon as practicable charge when- viduals in the facility would paragraph (c)(1)(i)(C) of viduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to the transfer or discharge, )(i)(B) of this section; usfer or discharge is nt's urgent medical needs, )(i)(A) of this section; or resided in the facility for 30 as of the notice. The written agraph (c)(3) of this section ving: nefer or discharge; of transfer or discharge; ich the resident is ged; resident's appeal rights, idress (mailing and email), r of the entity which s; and information on how m and assistance in ad submitting the appeal a (mailing and email) and	F 623		

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	D HUMAN SERVICES			:	FOR	M APPROVED D, 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A, BUILDING			e Survey Pleted	
		165344	B, WING			01	/29/2019
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				1808	MAIN STREET		
PEARL VA	LLEY REHABILITATION	AND NURSING AT GOWRIE,		GOV	VRIE, IA 50543		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) Completion Date
F 623	and developmental dis disabilities, the mailing telephone number of t the protection and adv developmental disabili C of the Development and Bill of Rights Act of codified at 42 U.S.C. 1 (vii) For nursing facility disorder or related dis- email address and tele agency responsible for advocacy of individual established under the for Mentally III Individual established under the for Mentally III Individual s483.15(c)(6) Change if the information in the effecting the transfer of must update the recipi as practicable once the becomes available. §483.15(c)(8) Notice k in the case of facility of the administrator of the written notification prior to the State Survey Ag State Long-Term Care the facility, and the reside 483.70(I). This REQUIREMENT by:	udeman; residents with intellectual sabilities or related g and email address and he agency responsible for rocacy of individuals with tiles established under Part al Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and residents with a mental abilities, the mailing and sphone number of the r the protection and s with a mental disorder Protection and Advocacy als Act. s to the notice. a notice changes prior to r discharge, the facility ents of the notice as soon e updated information advance of facility closure losure, the individual who is a facility must provide r to the Impending closure ency, the Office of the Ombudsman, residents of ident representatives, as o transfer and adequate onts, as required at § is not met as evidenced aw and staff interview the	F 6.	23			

FORM CMS-2587(02-99) Previous Versions Obsolete

Facility ID: 1A0117

If continuation sheet Page 9 of 25

PRINTED: 02/11/2019

		ND HUMAN SERVICES				: 02/11/20 APPROVE
TATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A, BUILDING	ONSTRUCTION	(X3) DATE COMPI	
		165344	B, WING		04/	9/2019
NAME OF F	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		JIZU 13
PEARL V	ALLEY REHABILITATIO	N AND NURSING AT GOWRIE,		B MAIN STREET WRIE, IA 50543		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X6) Completion Date
F 623	Continued From pag	e 9	F 623			
	Transfer to a represe State Long Term Car residents	entative of the Office of the re Ombudsman for 4 #8 and #2 ). The facility				
1	Findings include:					
	assessment referenc	linimum Data Set with e date 11/2/18 Resident #11 11, moderately impaired Ily decision making.	· · · · · · · · · · · · · · · · · · ·			
	Resident #11"s clinica resident had been ad 9/17/18- 9/26/18 and	mitted to the hospital				
		e date 11/7/18 Resident #14 13, cognitively intact skills				
	Resident #14's clinica resident had been hos 7/23/18-7/31/18 and 1	spitalized 4/18/18-4/22/18,				
		e date 10/26/18 Resident #8				
	Resident #8's clinical i was hospitalized 10/1	record showed the resident 7/18-10/21/18.				
	facility had not been n discharges to the hosp	lursing (ADON) stated the otifying the Ombudsman of				

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

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Event ID; FX9511

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If continuation sheet Page 10 of 25

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

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PRINTED;	02/11/2019
FORM	APPROVED
OMB NO.	0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING				(X3) DATE SURVEY COMPLETED		
		165344	B. WING			01.	/29/2019	
	OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1808 MAIN STREET L VALLEY REHABILITATION AND NURSING AT GOWRIE, GOWRIE, IA 50543							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	jd Prefi) Tag	×	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE API DEFIGIENCY)	IOULD BE	(X5) Completion Date	
F 623	transferred to the hos	ented Resident #2 was pital on 9/10/18. The MDS ented Resident #2 returned	Fe	523				
	Resident #2's medica documentation the Or notified of the residen	nbudsman had been t's transfer.						
F 625 SS=C	been notified of the re	the Ombudsman had not sident's transfer. Ilcy Before/Upon Trnsfr	F6	025				
	§483.15(d)(1) Notice I nursing facility transfe the resident goes on t nursing facility must p the resident or resider specifies- (i) The duration of the any, during which the return and resume resi facility; (ii) The reserve bed pa plan, under § 447.40 o (iii) The nursing facility bed-hold periods, which paragraph (e)(1) of this resident to return; and (iv) The Information sp of this section.	rovide written information to at representative that state bed-hold policy, if resident is permitted to idence in the nursing ayment policy in the state of this chapter, if any; 's policies regarding sh must be consistent with s section, permitting a becified in paragraph (e)(1) d notice upon transfer. At						

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Facility ID: IA0117

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 02/11/2019 MAPPROVEL O. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		165344	B, WING		01	/29/2019	
	ROVIDER OR SUPPLIER	AND NURSING AT GOWRIE,	18	REET ADDRESS, CITY, STATE, ZIP CODE 508 MAIN STREET OWRIE, IA 50543		·····	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION)	/ ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	TON SHOULD BE COMP THE APPROPRIATE D		
	facility must provide to resident representativ specifies the duration described in paragrap This REQUIREMENT by: Based on record revis facility failed to notify a residents representativ bed hold prior to trans hours after admitted to (Resident #11, #14, #8 reported a census of 3 Findings include: 1. According to the Mi assessment reference had a BIMS score of 1 cognitive skills for daily Resident #11's clinical resident had been adm 9/17/18- 9/26/18 and 1 clinical record lacked d notice provided to the mi assessment reference had a BIMS score of 13 for daily decision makin Resident #14's clinical resident had been hosp 7/23/18-7/31/18 and 1// documentation the resi	apeutic leave, a nursing o the resident and the e written notice which of the bed-hold policy h (d)(1) of this section. is not met as evidenced aw and staff interview the a resident and/or the ve of the facility policy for fer to a hospital or within 24 o a hospital for 4 residents, 8 and #2). The facility 00 residents. Inimum Data Set with date 11/2/18 Resident #11 1, moderately impaired v decision making. record showed the nitted to the hospital 0/11/18-10/18/8. The locumentation of bed hold resident or resident or hospitalization. Imum Data Set with date 11/7/18 Resident #14 3, cognitively intact skills og. record showed the oltalized 4/18/18-4/22/18, 24/19. The record lacked	F 625				

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

Event ID: FX9511 Faolity ID: IA0117

If continuation sheet Page 12 of 25

PRINTED: 02/11/2019

#### FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A, BUILDING 165344 B, WING 01/29/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1808 MAIN STREET PEARL VALLEY REHABILITATION AND NURSING AT GOWRIE, GOWRIE, IA 50543 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) わ (X4) 1D COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE **REGULATORY OR LSC IDENTIFYING INFORMATION)** TAG tag DEFICIENCY) F 625 Continued From page 12 F 625 F 625 (C) hold. The DON, their designee, as well as facility Nurses have reviewed the 3. According to the Minimum Data Set with Regulatory Requirements (483.15) assessment reference date 10/26/18 Resident #8 regarding the Notice of Bed-Hold had a BIMS score of 14, cognitively intact skills Policy and Return. The Facility has for daily decision making. implemented the Bed-Hold Policy and Resident #8's clinical record showed the resident instructed the Nurses to try to ensure was hospitalized 10/17/18-10/21/18. The record this document is addressed with the resident, as well as the resident's lacked documentation the resident or resident representative prior to the residents representative had been giving notification of bed discharge/transfer from the facility, or hold. addressed with the residents representative as soon as possible following the residents During interview on 1/29/19 at 8:15 AM the discharge/transfer from the facility. Assistant Director of Nursing (ADON) stated the facility had not been giving residents or resident The DON, or their designee, will representative notification of bed hold when monitor that this practice of Bed-Hold notification is completed. Identified admitted to the hospital. concerns to Quality Assurance for 4. A Minimum Data Set (MDS) assessment tool, resolution. dated 9/10/18 documented Resident #2 was transferred to the hospital on 9/10/18. An MDS, This represents my credible allegation dated, 9/20/18 documented Resident #2 returned of compliance effective 02/01/2014 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 655 F 655 | **Baseline Care Plan** CFR(s): 483,21(a)(1)-(3) SS=C §483.21 Comprehensive Person-Centered Care Facility ID: IA0117 If continuation sheet Page 13 of 25 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: EX9511

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED; 02/11/2019

	IMENT OF HEALTH AN				FO	ED: 02/11/2019 RM APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	CONSTRUCTION	(X3) DA	10.0938-0391 TE SURVEY MPLETED	
		165344	B. WING	·····	0	1/29/2019
NAME OF F	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CC		
PEARL V	ALLEY REHABILITATION	AND NURSING AT GOWRIE,		08 MAIN STREET DWRIE, IA 50543		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE IE APPROPRIATE	(X5) Completion Date
	Planning §483.21(a) Baseline C §483.21(a)(1) The faci implement a baseline that includes the instru- effective and person-of that meet professional The baseline care plan (I) Be developed within admission. (II) Include the minimum necessary to properly of including, but not limite (A) Initial goals based (B) Physician orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (E) Social services. (F) PASARR recomme §483.21(a)(2) The facil comprehensive care pl care plan if the compre- (I) Is developed within admission. (II) Meets the requiremed (b) of this section (excet this section). §483.21(a)(3) The facil resident and their repre- of the baseline care pla limited to: (I) The initial goals of ti (II) A summary of the re- dietary instructions. (III) Any services and the	Care Plans lility must develop and care plan for each resident totions needed to provide entered care of the resident standards of quality care. n must- n 48 hours of a resident's m healthcare information care for a resident ad to- on admission orders. Ity may develop a an in place of the baseline thensive care plan- 48 hours of the resident's ents set forth in paragraph opting paragraph (b)(2)(I) of lity must provide the esentative with a summary in that includes but is not he resident. esident's medications and	F 655			

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Facility ID: IA0117

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#### **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO, 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING 165344 B. WING 01/29/2019 NAME OF PROVIDER OR SUPPLIER. STREET ADDRESS, CITY, STATE, ZIP CODE **1808 MAIN STREET** PEARL VALLEY REHABILITATION AND NURSING AT GOWRIE, GOWRIE, IA 50543 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X6) **I**D (X4) ID COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 655 Continued From page 14 F 655 on behalf of the facility. (iv) Any updated information based on the details F 655 (C) of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced The DON, and their designee, have reviewed and been informed of the by: Based on record review and staff interview the importance of complying with the facility failed to complete baseline care plans Regulatory Requirements (483.21) within 48 hours after admission for two (2) regarding the Development of Baseline residents, (Resident #14, and #8). The facility Care Plans within 48 hours of a reported a census of 30 residents. resident's admission. Comprehensive Care Plans have been developed and Findings include: implemented for Resident 14 (expired 02/05/2019) and Resident 8. The 1. Review of Resident #14's clinical record D.O.N., or their designee, will conduct showed the resident had been admitted to the random audits and bring identified facility on 3/13/18. The record lacked a baseline issues to QA. care plan. This represents my credible allegation 2. Review of Resident #8's clinical record showed of compliance effective 02/01/2019 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. Services Provided Meet Professional Standards F 658 F 658 F 658 (D) CFR(s): 483.21(b)(3)(i) SS=D The facility has contacted Resident §483.21(b)(3) Comprehensive Care Plans #27's Pharmacy to inform them of The services provided or arranged by the facility, the necessity to have them include as outlined by the comprehensive care plan, Physician ordered parameters for holding beta blocker medications must-(i) Meet professional standards of quality. on his, or any residents, MAR. This REQUIREMENT is not met as evidenced For those residents who receive beta by: blocker medications and use a cont ..... Based on clinical record review and staff interview, the facility failed to follow physician

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: IA0117

If continuation sheet Page 15 of 25

PRINTED; 02/11/2019

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TATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY IPLETED
		165344	B, WING		01	/29/2019
NAME OF P	ROVIDER OR SUPPLIER	I		REET ADDRESS, CITY, STATE, ZIP CODE		
PEARL V	LLEY REHABILITATION	AND NURSING AT GOWRIE,		OWRIE, IA 50543		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LO BE	(X5) COMPLETION DATE
F 658	Continued From page	9 15	F 658			
	orders for 1 of 16 resi #27). The facility repo	dents reviewed (Resident rted a⊧census of 30		F 658 (D)		
	residents. Findings include:			The facility has contacted Resid #27's Pharmacy to inform them the necessity to have them inclu Physician ordered parameters for	of de	
	assessment dated 12/	nimum Data Set (MDS) /23/18 Resident #27 had ed, Hypertension, Peripheral		holding beta blocker medication on his, or any residents, MAR. For those residents who receive	18	
	Vascular disease and	depression. The MDS with a Brief Interview for		blocker medications and use a different Pharmacy the facility h attempted to ensure that Physici	188	
	indicated moderately l abilities, and required	mpaired decision making limited assistance with d supervision with eating.		approved parameters for holding blocker medications are noted o those residents MAR's. The fac	g beta n	
		ff to administer Metoproloi		Nurses reviewed the Administra of Medication Policy and have b informed of the importance of	tion	
	twice a time a day rela all Beta Blocker Medic	ive one tablet by mouth ted to hypertension, Hold ation if pulse less than 60,		obtaining resident $\#27$ 's, or any other resident receiving beta blocker medications, pulse and		
	or systolic blood press Review of the Medicat	ure less than 110. ion Administration Record		blood pressure to confirm the residents pulse and blood pressu are within the Physician ordered	re	
	(MAR) for 11/1/18-11/ Administration Record pulse and blood press	falled to include the daily		parameters for administration of the medication. The DON, or the designee, will perform random a	eir udits	
:	11/28/18, documented	and Vitals Flow sheet dated vitals completed on pht for 12/1/18 and 1/5/19.		and bring any identified concern Quality Assurance.		
	Review of the Skilled D	ally Nursing Notes on		This represents my credible alleged of compliance effective <b>02/08/2</b>		
	these dates document 12/3/18 at 52 12/8/18 at 54	ed the residents pulse:				
	12/12/18 at 52 12/13/18 at 50 12/14/18 at 52					

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	MENT OF HEALTH AN			·	PRINTED: 02/11/2019 FORM APPROVED OMB NO, 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		165344	B. WING		01/29/2019
	ROVIDER OR SUPPLIER	AND NURSING AT GOWRIE,	18	IREET ADDRESS, CITY, STATE, ZIP CODE 508 MAIN STREET OWRIE, IA 50543	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
SS≖D	12/15/18 at 58 12/16/18 at 54 for the night shift 12/22/18 at 54 12/23/18 at 56 Review of the MAR fo Medication Administra Include the daily puise During an interview or facility director of nurs that the MAR falled to and puises and that the is to follow the physici During an interview or facility corporate qualit confirmed and verified pressures were not on expectation is for the r physicians orders. ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A reside out activities of daily in services to maintain go personal and oral hygi This REQUIREMENT by: Based on observation interview, and facility p failed to provide complincontinence care for 1	day shift and 54 for the r 1/1/19-1/31/19, the tion Record falled to and blood pressures. a 1/29/19 at 10:05 a,m,. the ing confirmed and verified address the blood pressure e expectation of the nurses ans orders as written. a 1/29/19 at 1:18 p.m., the y assurance nurse that the pulse and blood the MAR and that the surses to follow the blood pressure confirmed and verified address the blood pressure e expectation of the nurses ans orders as written. a 1/29/19 at 1:18 p.m., the y assurance nurse that the pulse and blood the MAR and that the surses to follow the blood pressure confirmed and verified address the necessary blood nutrition, grooming, and ene; is not met as evidenced , record review, staff olicy review the facility ete and proper of 3 residents reviewed Resident #84). and the to f 13 active residents	F 677	different Pharmacy the facility has attempted to ensure that Physician approved parameters for holding be 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 audi and bring any identified concerns to Quality Assurance. This represents my oredible allegatio of compliance effective 02/08/2019	Y 1 1 1 1

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Facility ID: IA0117

If continuation sheet Page 17 of 25

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		CONSTRUCTION	OMB NO. 0938-( (X3) DATE SURVEY COMPLETED	
		165344	B. WING		01/2	9/2019
	ROVIDER OR SUPPLIER	AND NURSING AT GOWRIE,	180	REET ADDRESS, CITY, STATE, ZIP CODE 18 MAIN STREET WRIE, 1A 50543		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) Completion Date
	census of 30 residen Findings include: 1. According to the M assessment with a re Resident #84 had dia anemia, hypertension subarachnoid hemorr activities due to disab the resident with shor impairments and seve making abilities, and i with all aspects of dai assessment documer incontinent of bladder The Baseline care pla 1/15/19 stated incontil with peri cares done b During an observation Staff A and Staff B (Ce proceeded to provide resident. Staff A clean right groin and then m and Staff B then positi side, Staff A cleansed buttock area with wet cleanse from back to f area to the peri area. During an interview or facility DON confirmed the peri area and cocc	A183). The facility reported a ts. Inimum Data Set (MDS) ference dated of 1/22/19 gnoses that included a, asthma, nontraumatic hage, and limitation of ility. The MDS documented t and long term memory prely impaired in decision required total assistance ly living. The MDS need the resident as always and bowel. In with an admit date of nent of bowel and bladder by the staff. In on 1/28/19 at 8:12 AM ertified Nursing Assistants) Incontinency cares on the sed the resident's left and iddle of peri area, Staff A ion the resident on the right the residents left hip and wipes, then proceeded to front on the resident coccyx A 1/29/19 at 9:30 AM the I Staff A needed to cleanse syx area from front to back.	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 inform that failure to provide appropriate care to Residents #21, #84, and #18 or any other resident, may result in disciplinary actions up to and including termination. The DON, of their designee, will perform random audits and bring any identified conce to Quality Assurance. This represents my credible allegati of compliance effective <b>02/01/2019</b>	s eed 3, r erns on	

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DEPARTMENT OF HEALTH AN	D HUMAN SERVICES
CENTERS FOR MEDICARE & M	MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PRINTED:	02/11/2019
FORMA	<b>VPPROVED</b>

· · · ·	<u>OMB NO. 0938-0391</u>	
	(X3) DATE SURVEY COMPLETED	
_	01/29/2019	

AND PLAN OF CORRECTION IDENTI		IDENTIFICATION NUMBER:	A, BUILDING		COMPLETED	
		165344	B. WING		·	01/29/2019
NAME OF PROVIDER OR SUPPLIER PEARL VALLEY REHABILITATION AND NURSING AT GOWRIE,		180	REET ADDRESS, CITY, STATE, ZIP CODI 8 MAIN STREET WRIE, IA 50543	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF(X TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) Completio Date
	down one side, then ti wash Front to Back. T each wipe and dry. 2. A Minimum Data Se dated 12/1/18 docume Brief Interview for Mer 11. A score of 8 to 12 impaired cognition. Th resident had total dep mobility, transfers, toli hygiene hygiene, inclu MDS documented the included heart failure, weakness and difficult The resident's care pla 12/13/17 documented assistance with activiti weakness and decrease During an interview 1/2 resident stated he had had not helped him bru During an interview will Nursing) and ADON (A Nursing) present on 1/2 and Staff B, CNA's sta	eparate genitalia wash he other making sure to furn the cloth surface with et (MDS) assessment tool ented Resident #21 with a natal Status (BIMS) score of indicates moderately the MDS revealed the endence on staff for bed et use, and personal iding brushing teeth. The resident's diagnoses diabetes, muscle y walking. an with a revision date of the resident required staff es of daily living due to sed mobility. 27/19 at 1:55 PM the his own teeth and the staff ush his teeth for awhile. th the DON ( Director of assistant Director of 28/19 at 11:15 AM Staff A ted they had not helped the esh this morning during 28/19 at 11:15 AM the	F 677			

(X2) MULTIPLE CONSTRUCTION

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Facility ID: IA0117

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		ND HUMAN SERVICES			PRINTED: 02/11/2010 FORM APPROVED OMB NO, 0938-0397
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		165344	B. WING		01/29/2019
NAME OF	PROVIDER OR SUPPLIER	· · ·		REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
PEARL V	ALLEY REHABILITATION	AND NURSING AT GOWRIE,		108 MAIN STREET OWRIE, IA 50543	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 677	Continued From page	ə 19	F 677		
	season, places, name	act, alert, and oriented to is, and faces, and family possibly confused with			
	resident stated staff h with brushing her teeti reported she normally would like her teeth br	1/28/19 at 8:53 AM the ad not offered assistance h since admission. She brushed her teeth dally and rushed. She stated a family ing her a tooth brush and			
	CNA stated she helped	28/19 at 11:18 AM Staff A, d the resident get out of rted the resident directly to sisting her with oral			
F 679	and ADON obtained a paste and directed Sta with brushing her teeth Activities Meet Interest	If A to help the resident i immediately.	F 679	<b>F 679</b> (D)	
\$S≃D	the comprehensive ass and the preferences of program to support res activities, both facility-s individual activities and designed to meet the in physical, mental, and p	I independent activities, nterests of and support the osychosocial well-being of ging both independence		AD is now personally and has direct her Activity Asst, to bring Resident out to those group activities of his choice and document refusals. The will continue 1 on 1's; developing a acceptable 1 on 1 program for each resident to meet their individual nee The AD, or their designee, will bring any identified concerns to Quality Assurance. This represents my credible allegatio of compliance effective 02/08/2019	21 AD n ds.

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Event ID: FX9511

Facility ID: IA0117

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		D HUMAN SERVICES			۰,	FOR	D: 02/11/2019
STATEMENT	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER;	(X2) MULT A. BUILDI		ECONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		165344	B, WING_			01/	29/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PEARL V	LLEY REHABILITATION	AND NURSING AT GOWRIE,			1808 MAIN STREET GOWRIE, IA 50543		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
- F 679	by: Based on observation resident and staff inter ensure 1 of 13 resider activity program of cho facility reported a cens Findings include: 1. A Minimum Data Se dated 12/1/18 docume Brief Interview for Mer 11. A score of 8 to 12 I impaired cognition. Th resident required supe total dependence on s transfers, toilet use, ar hygiene. The MDS doo diagnoses included he muscle weakness and MDS revealed the resi important to have bool magazines to read and and not important at al people. The resident's Activitile allow the resident to m between a shower and when nice encourage I church services, and s isolation (last review di lacked documentation and any activities brou resident.	Is not met as evidenced a, record review and rview, the facility failed to ats received an ongoing bloce (Resident #21). The sus of 30 residents. at (MDS) assessment tool onted Resident #21 with a tal Status (BIMS) score of indicates moderately e MDS revealed the rvision with eating and had taff for bed mobility, and personal hygiene cumented the resident's art failure, diabetes, difficulty walking. The dent felt it was very ts, newspapers, and i keep up with the news i to be with groups of s care plan directed staff to ake choices, choose a tub, bath, go outside nvolvement with Bingo, o on, and report signs of ate 12/1/18). The care plan of any one to one activities ght to the room for the per 2018 and January 2019	F	379			
		d the resident frequently			·		

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Facility ID: 1A0117

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 165344			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B. WING		01/29/2019		
	ROVIDER OR SUPPLIER	AND NURSING AT GOWRIE,		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 MAIN STREET GOWRIE, IA 50543		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 679	attended coffee/tea a watched television. T schedule revealed Bl 2:00 PM. Observation 1/29/19 activity in the dining r present. During an interview o stated the resident wa	nd chatter, socializing, and he January 2019 activity ngo scheduled on 1/29/19 at at 2:52 PM revealed Bingo oom and Resident #21 not n 1/29/19 at 4:00 PM the AD as on the bed pan when she	F 67	9		
<ul> <li>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.</li> <li>F 727 RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3)</li> <li>§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.</li> <li>§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.</li> <li>§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:</li> <li>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.</li> </ul>		Full Time DON (3) d nurse when waived under this section, the facility of a registered nurse for at ours a day, 7 days a week. when waived under this section, the facility stered nurse to serve as the a full time basis. ector of nursing may serve y when the facility has an icy of 60 or fewer residents. is not met as evidenced ew and staff interview the e eight (8) consecutive urse, RN, coverage seven	F 727	<ul> <li>F 727 (E)</li> <li>The DON, and/or their designed have reviewed the Regulatory Requirements (483.35(b) and 483.5(b)(1) regarding the necessity of RN coverage for a least 8 consecutive hours a day 7 days a week. The DON, or the designee will ensure compliant with this Regulatory Requirem The DON, or their designee, w perform random audits and bri identified concerns to Quality Assurance.</li> <li>This represents my credible all of compliance effective 02/04/</li> </ul>	t heir ce lent. rill ng any egation	
1	FindIngs include:					

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES					<b>NO. 0938-0391</b> TE SURVEY	
of deficiencies of correction					COMPLETED	
165344		B, WING			1/29/2019	
PROVIDER OR SUPPLIER	••••••••••••••••••••••••••••••••••••••		STREET ADDRESS, CITY, STATE, ZIP CO	DE	•	
ALLEY REHABILITATION	AND NURSING AT GOWRIE,		1808 MAIN STREET GOWRIE, IA 50543			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
Continued From page	ə 22	F 7:	27			
through January 27, 2	2019, revealed no RN					
<ol> <li>Sunday, December</li> <li>Thursday, January</li> <li>Saturday, January</li> <li>Saturday, January</li> </ol>	r 23, 2018 1, 2019 5, 2019 19, 2019					
facility DON (Director were not aware of the eight (8) hours of RN	of Nursing) stated that they regulation that required coverage daily and that					
facility corporate quali confirmed there was in coverage on the days DON confirmed that the an RN scheduled on en Nurse Alde Registry V	ty assurance nurse no RN scheduled or and dates listed above. The ne facility needed to have overy day of the week. erification, Retraining	F 72	9			
Before allowing an ind aide, a facility must re- that the individual has requirements unless- (i) The individual is a fit training and competen approved by the State (ii) The individual can p recently successfully of	ividual to serve as a nurse celve registry verification met competency evaluation ull-time employee in a cy evaluation program ; or prove that he or she has completed a training and					
	OF DEFICIENCIES FORRECTION PROVIDER OR SUPPLIER ALLEY REHABILITATION SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page Review of the schedu through January 27, 2 scheduled to work on 1. Saturday, December 3. Thursday, January 4. Saturday, January 5. Saturday, January 6. Friday, January 6. Friday, January 6. Friday, January 7. Saturday, January 8. Saturday, January 9. Saturday, January 9. Saturday, January 9. Saturday, January 9. Saturday, January 9. Friday, January 9. Saturday, January 9. Saturd	OF DEFICIENCIES       (X1) PROVIDER/SUPPLER/CLIA         IDENTIFICATION NUMBER:       165344         PROVIDER OR SUPPLIER       165344         ALLEY REHABILITATION AND NURSING AT GOWRIE,       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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.         Nurse Alde Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6)         §483.35(d)(4) Registry verification.         Bofore allowing an individual to serve as a nurse alde, a facility must receive registry verification that the individual has met competency evaluation	OP DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTI         IDENTIFICATION NUMBER:       (X2) MULTI         ALLEY REHABILITATION AND NURSING AT GOWRIE,       B. WING	OPE DEFIDENCIES       [X1] PROVIDESUSUPPLENCLA       (X2) MULTPLE CONSTRUCTION         PORTRECTON       165344       B. WING         165344       B. WING	OF DEFICIENCIES       [K1] PROVIDERVALUAL       (22) MULTIPLE CONSTRUCTION       (23) DA         IF GORRECTION       165344       8. WING       (26)         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       (26)         ALLEY REHABILITATION AND NURSING AT GOWRIE, (BODI DEFICIENTY MAY STATE INTECODE DE FILL RECULATORY OR LSD IDENTIFYING MYORIANTICH)       PD PROVIDERS PLANOF CORRECTION (BODI DEFICIENTY MAY STATE INTECODE DE FILL RECULATORY OR LSD IDENTIFYING MYORIANTICH)       PD PROVIDERS PLANOF CORRECTION (BODI DEFICIENTY MAY STATE INTECODE DE FILL RECULATORY OR LSD IDENTIFYING MYORIANTICH)       PD PROVIDERS PLANOF CORRECTION (BODI DEFICIENTY MAY STATE INTECODE DE FILL RECULATORY OR LSD IDENTIFYING MYORIANTICH)       PD PROVIDERS PLANOF CORRECTION (BODI DEFICIENTY)       PD PROVIDERS PLANOF CORRECTION (BODI DEFICIENTY)	

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		165344	B. WING		0	1/29/2019	
NAME OF PROVIDER OR SUPPLIER PEARL VALLEY REHABILITATION AND NURSING AT GOWRIE,		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 MAIN STREET GOWRIE, IA 50543					
(X4) ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE & CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X6) COMPLETIO DATE	
	evaluation program al has not yet been inclu Facilities must follow individual actually bed §483.35(d)(5) Multi-St Before allowing an inc aide, a facility must se State registry establisi (2)(A) or 1919(e)(2)(A belleves will include in §483.35(d)(6) Require If, since an Individual's a training and compete there has been a conti consecutive months di individual provided nui services for monetary individual must comple competency evaluation competency evaluation this REQUIREMENT by: Based on review of er interview the facility fai assistants were listed prior to hire (Staff C). T census of 30 residents Findings included: 1. A review of employee hired Staff C as a Certi (CNA) on 10/30/18. Th documentation that sho verified the nursing ass	pproved by the State and ided in the registry. up to ensure that such an comes registered. tate registry verification. lividual to serve as a nurse teck information from every hed under sections 1819(e) ) of the Act that the facility formation on the individual. d retraining. s most recent completion of ency evaluation program, inuous period of 24 uring none of which the rsing or nursing-related compensation, the set a new training and o program or a new o program. is not met as evidenced mployee files and staff ied to assure all nursing on the Nurse Alde Registry The facility reported a e files revealed the facility fied Nursing Assistant e record lacked powed the facility had	F 7:	F 729 (E) The Facility Adminis Staff C's CNA Registion 1-29-19. The Facilic completed a Single C Background Check for 01-29-19. On 02-13- Administratorcontacta to a Record Check Events Staff C's employment informed that based on DCI report indicating criminal charges beint Criminal History Rap prior back ground In I from which DHS cleas for Staff C to work for stated since there were the Rap Sheet, this en approved to be employ setting. The Administ their designee, have re Regulatory Requirement regarding performing background checks an Requirements (483.35 CNA Registry verificat to offering employment any other applicants. Administrator, DON, will confirm the comp Single Contact Licens Check and CNA Regist Licensure prior to app offered employment.	tration lity Administrator ontact License and or Staff C on 19 the ed DHS pertaining valuation regarding t status and was n the 01-29-19 no further g listed on the Sheet since the March of 2018 red April 9, 2018 r this Agency and e no new hits on aployee would be yed in a LTC trator/DON, or eviewed the ents (483.12) criminal d the Regulatory i(d)(4) regarding ation checks prior nt to Staff C, or The or their designee, letion of the e and Background stry / Staff		

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

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			· · · ·	OMB N	0.0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		165344	B. WING	<b>,</b>		01	/29/2019
NAME OF PROVIDER OR SUPPLIER PEARL VALLEY REHABILITATION AND NURSING AT GOWRIE,			STREET ADDRESS, CITY, STATE, ZIP CODE 1808 MAIN STREET GOWRIE, IA 50543				
(X4) ID PREFIX TAG	(EACH DEF/CIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X6) COMPLETION DATE
F 729	facility Administrator of complete a Single Co Background Check pr Staff C, and verified th documentation that in facility completed It. During an interview or facility Administrator re Single Contact Licens for Staff C. The form, documentation that ver	n 1/28/19 at 4:14 PM, the onfirmed he did not ntact License and lor to hire (10/30/18) for ne record lacked any	F	729	Any ongoing concerns will be addressed with the QA Committee. This represents my credible allegat of compliance effective 02/01/2019	ion	

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Facility ID: IA0117

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