STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 12.13.19 A re-certification survey and investigation of complaints #86993-C, 86892-C, 86037-C, and 85425-C completed 11/18-21/19 resulted in the following deficiencies. Complaint #86037 and #86892 were substantiated. Complaint #86993 and #85425 were not substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165468	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 580	Continued From page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify a Physician in a timely manner in regards to a skin condition for 1 of 13 active residents reviewed (Resident #17) and failed to notify the family of a change in medication for 1 of 13 active resident's reviewed (Resident #8). The facility reported a census of 21 residents. Findings included: 1. According to a Physician's Order Report form dated 8/18/2019-9/8/2019, Resident #17's diagnoses included paralytic syndrome. The order form included an order for baby powder	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165468	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	606 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 580	Continued From page 2	F 580		

with corn starch to any area that produced heat and redness such as abdominal folds and groin areas.

A Minimum Data Set (MDS) Assessment dated 7/29/19, identified the resident's Brief Interview Mental Status (BIMS) score as 14, indicative of fully intact cognition.

A Nurse's Note dated 8/22/19 at 4:00 P.M., revealed the resident had loose stools and described his groin and rectal area as bright red. Staff documented a facsimile (fax) had been sent to his Medical Provider for an order to resolve the irritation. Further record review revealed no record of a fax being sent to a Medical Provider.

A Nurse's Note dated 8/25/19 at 3:00 P.M., revealed the resident reported pain in his groin from irritation and noted powder thick in his groin creases. Staff documented a fax being re-sent to the resident's Medical Provider with a request for antifungal cream. Further record review revealed no fax sent to a Medical Provider.

A Nurse's Note dated 8/29/29 at 7:30 A.M., revealed the resident's groin remained reddened, but improved.

A Nurse's Note dated 9/21/19 at 5:30 A.M., revealed the resident continued with a rash in his groin.

A Nurse's Note dated 9/21/19 at 2:10 P.M., revealed staff faxed a Medical Practioner in regards to the resident's groin rash and requested a medication to treat the area.

A Nurse's Note dated 9/23/19 at 1:05 P.M.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 580	Continued From page 3 revealed staff received an order for Nystatin powder to the resident's groin rash. Review of Resident #17's Medication and Treatment Flowsheets dated 8/1/19- 8/31/19, revealed no medication orders or treatment orders for the resident's groin rash. During interview on 11/21/19 at 7:30 A.M., Staff L, Registered Nurse (RN) confirmed if a response had not been received from a fax sent to a Physician in regards to a medical condition, Nurses are to re-fax the Physician. During interview on 11/21/19 at 8:50 A.M., the facility Director of Nursing (DON) stated she expected nurses to re-fax a Physician no later than 1 week after no response had been attained from an initial fax. 2. According to the MDS assessment, dated 7/14/19, Resident #8 scored 7 on the BIMS, indicating severe cognitive impairment. The resident received scheduled pain medication. The Nurse's Notes dated 9/10/19 documented the resident transferred and admitted to the hospital for pneumonia. A hospital Clinical Summary dated 9/13/19 included orders to stop taking Hydrocodone (narcotic pain medication for moderate to severe pain) 2 times a day. The Nurse's Notes dated 9/13/19 at 2 p.m. documented the resident returned to the facility with new orders for an antibiotic and the resident's Hydrocodone discontinued. The resident's family member visited and aware of the	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	606 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 580	Continued From page 4 resident's diagnosis and new antibiotic. A Skilled Daily Nurse's Note dated 9/17/19 at 4 p.m. documented the resident complained of abdominal discomfort, crying out and swearing. The resident's family member attempted to calm the resident. The physician made rounds and the family member requested to restart the Hydrocodone 2 times a day. During an interview on 11/20/19 at 9:32 a.m. the resident's family member stated the doctor came to see the resident because she had so much pain. She said the doctor told her she had accidentally taken the resident off Hydrocodone in the hospital. The family member stated she did not know this, and thought she should have been notified. During an interview on 11/21/19 at 8:10 a.m. the DON and the Interim Administrator stated they felt it was the hospital's responsibility to tell the family of changes made while hospitalized.	F 580	The facility has reviewed its practices regarding notifying physicians. The DON or their designee will review Fax Out's to the physician weekly X4 weeks, then monthly X12 months to assure timely physician notification. Charge nurses have been educated on the physician and family notification protocols. Skin assessments will be audited weekly X4 weeks and monthly X12 months by the DON or their designee. Any ongoing concerns will be addressed with the QA committee. This represents the facilities credible allegation of compliance as of 12-4-19.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) 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(i)(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	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	606 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 584	Continued From page 5 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(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §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, record review and staff interview, the facility failed to assure the resident's had a safe, clean and homelike environment. The facility reported a census of 21 residents. Findings include: During observation on 11/19/19 at 2:22 p.m. noted the following:	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	606 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 584	Continued From page 6 a. 2 windows to the east in the common area were warped to the point they had gaps between the windows and the window frame, with noted rotting in areas. b. The carpet in the common areas had large dark stains in multiple areas. Stains were also noted in other areas of the carpeting, including across from the nurses station and down the east hall. There were dark stains on the carpet in the southwest corner of room 30 and a dark stain on the carpet in room 105. c. The south wall in room 110 looked marred or dirty. d. The west door to the kitchen had a grimy area in front of it. e. White stains on the carpet by the east and west walls of the dining area. During an interview on 11/19/19 at 2:58 p.m. the Administrator concurred the windows were in need of repair or replacement. She confirmed the carpet had stains and did not look homelike. During an observation on 11/20/19 at 2:57 p.m. the wall south of the (whirlpool) tub had several inches of damage with black discoloration from the floor up, with a lesser degree to the west wall. The heat register was loose and a potential hazard. The linoleum flooring had areas with holes or gauges making it unsanitizable. During an interview on 11/20/19 at 3:22 p.m. the Maintenance Man stated he had worked at the facility for about 2 weeks and he did help put the new whirlpool in. He knew of the issues in the whirlpool room and thought they needed to do something with the wall and with the floor.	F 584	The two windows to the east in the common area have been closed and latched securely on 11-19-19. The carpet in the commons area, nurses station and down the east hall have been cleaned with a carpet shampooer on 12-5-19. Dark stain in the southwest corner of room 30 has been cleaned along with carpet in room 105 on 12-5-19. The facility realizes the need for new flooring and is currently getting quotes to obtain new flooring. The whirlpool room is currently under construction and quotes to replace wall and flooring are being completed. The south wall in room 110 was cleaned as of 12-5-19. The west door to the kitchen was cleaned as of 12-5-19. The dining room carpet by the east and west walls were cleaned as of 12-5-19. Any ongoing concerns with be addressed with the QA committee. The represent the facilities credible allegation of compliance dated 12-13-19.	
F 606	Not Employ/Engage Staff w/ Adverse Actions	F 606		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165468	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	606 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 606 SS=D	Continued From page 7 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 employee file review, staff interview and policy review, the facility failed to receive a record check evaluation from the Department of Human Services in regards to a perspective employees criminal conviction prior to hire, for 1 of 8 employee files reviewed (Staff J). The facility reported a census of 21 residents. Findings included: Review of Staff J's employee file revealed a hire date of 5/13/19 and job start date of 5/15/19.	F 606		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165468	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	606 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 606	Continued From page 8 Staff J's Single Contact License & Background Check (SING) form dated 5/13/19, revealed further research required into the staff members criminal history. Review of a Iowa Department of Human Services (DHS) Record Check Evaluation form, with a facsimile date of 5/28/19, revealed the facility had not received clearance from DHS until 5/28/19 for Staff J's clearance to work in the facility. A time card report form revealed Staff J worked in the facility 5/18/19, 5/19/19, 5/23/19, 5/24/19, 5/25/19, 5/26/29, 5/27/29 and 5/28/19. Review of a facility Abuse, Neglect and Exploitation policy, not dated, included the following: Employee Screening: Background checks should be conducted on employees prior to or at the time of employment by facility administration in accordance with applicable state and federal regulations. During interview on 11/19/19 at 12:30 P.M., the Provisional Administrator stated she had no knowledge in regards to Staff J and her start date prior to a DHS record check evaluation.	F 606	The facility administration has reviewed the procedures regarding record check evaluations on new employee's, to have completed prior to being employed. The Administrator or their designee will review record check evaluations prior to new employees starting. The Administrator or their designee will review any issues with the QA committee. This represents the facilities credible allegation of compliance dated 12-13-19.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165468	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	606 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 657	Continued From page 9 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to update the care plan for 1 of 13 residents reviewed (Resident #18). The facility reported census of 21 residents. Findings include: According to the Minimum Data Set assessment, dated 10/30/19, Resident #18 scored 4 on the Brief Interview for Mental Status, indicating severe cognitive impairment. Resident #18's diagnoses included urinary tract infection, multiple drug resistant organism and Alzheimer's disease. A facsimile (fax) dated 11/7/19; notified the physician the lab reported the resident had	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 657	Continued From page 10 positive results for Clostridium Difficile (bacterial inflammation of the colon) and had recently been treated for the same. The physician ordered Vancomycin for 10 days. During an observation on 11/19/19 at 1:39 p.m. a cart outside the residents door contained supplies. During an interview on 11/19/19 at 1:44 p.m. Staff M, Certified Nursing Assistant (CNA) stated the resident was on contact precautions. The current Care Plan lacked identification of the resident requiring contact precautions or interventions. During an interview on 11/20/19 at 11:32 a.m. the Director of Nursing stated the Care Plan should have been updated with the c-diff and isolation precautions.	F 657	Education was provided to charge nurses to update the care plan daily regarding any type of significant change regarding the residents plan of care on 12-11-19. DON or their designee will review care plans frequently to ensure appropriate interventions are in place. DON or their designee will review any issues with the QA committee. This represents the facilities credible allegation of compliance dated 12-13-19.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.	F 661		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	508 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 661	Continued From page 11 (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and policy review, the facility failed to complete a discharge summary with a recapitulation of the resident's stay at the time of discharge from the facility, for 1 resident discharged to home ((Resident # 25). The facility reported a census of 21 residents. Findings included: Record review revealed a facsimile dated 9/5/19 and an order for the resident to be discharged to home on 9/7/19. A Physician Note dated 9/6/19, revealed Resident #25's Physician documented the resident had known medical conditions that included hypertension, chronic kidney disease, chronic peripheral edema, atrial fibrillation, arthritis and degenerative disc disease. Review of Nurse's Notes dated 9/7/19, revealed the resident's family arrived at the facility to	F 661		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 661	Continued From page 12 discharge the resident to her home. Resident #25's record lacked a discharge summary and recapitulation of the resident's stay at the facility. During interview on 11/20/19 at 12:22 P.M., the facility Director of Nursing confirmed she had not been aware of a recapitulation requirement at the time of a resident's discharge to home. A facility Discharge to Home Policy and Procedure, with a review date of 2/22/08, included a policy for each resident to have the proper documentation in a resident's chart upon discharge from the facility. The procedure directed staff to complete a discharge summary and recapitulation of a resident's stay in the facility.	F 661	The facility has reviewed its recapitulation policy on all discharges. Charge nurses have been educated on the discharge recapitulation and that it is to be completed for every discharge and to include all other departments on 12-13-19. DON or their designee will perform random audits on all discharge recapitulation. Any issues will be reviewed with the QA committee. This represents the facilities credible allegation of compliance dated 12-15-19.	
F 677 SS=E	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 and staff interview, the facility failed to assure residents unable to carry out activities of daily living (ADL's) received the necessary services to maintain grooming, and personal and oral hygiene for 4 of 13 residents reviewed.(Resident #1, #3, #4, and #20). The facility reported a census of 21 residents. Findings include:	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 677	Continued From page 13	F 677		

1. According to the Minimum Data Set (MDS) assessment, dated 8/17/19, Resident #1 scored 3 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The resident received extensive assistance with bathing. The resident's diagnoses included Alzheimer's disease.

The ADL Flowsheet indicated the resident would have a bath on Tuesdays and Fridays.

A review of Weekly Skin Assessments, ADL Flowsheets and ADL status sheets revealed the resident had no documentation of receiving a bath between 7/9-16/19, 7/20-27/19, 7/27-8/6/19, 8/20-27/19, 8/27-9/3/19, 9/18-24/17, 10/1-7/19, and 10/8-15/19.

2. According to the MDS assessment, dated 10/5/19, Resident #8 scored 5 on the BIMS, indicating severe cognitive impairment. The resident depended on staff for toilet use and personal hygiene. The resident's diagnoses included Alzheimer's disease.

The current Care Plan edited 10/17/19, identified the resident had urinary incontinence. The interventions included providing incontinent care 2 times a day and as needed.

During an observation on 11/19/19 at 11:02 a.m. Staff A, Certified Nursing Assistant (CNA) and Staff M, CNA transferred the resident to the toilet with a gait belt. The resident had urine incontinence. When finished on the toilet Staff A wiped the resident's anal area 3 times with disposable wipes. Staff removed gloves and pulled up the resident's pants. Staff failed to clean

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 677	Continued From page 14 the resident's groins, perineal or suprapubic areas. During an interview on 11/21/19 at 8:10 a.m., the Director of Nursing (DON) stated she expected complete incontinent care. She stated a resident should be cleansed in the front as well as the back. The facility Peri Care Policy and Procedure dated 9/26/19, included wiping all exposed areas contaminated with stool or urine. The current Care Plan edited 10/25/19, identified the resident had a self care deficit. The interventions included providing denture/oral care with a.m./bedtime cares. During an observation on 11/20/19 at 7:30 a.m., Staff C, CNA and Staff I, CNA provided a.m. cares including pericare and dressing. Staff I put the resident's top denture in. Staff wheeled the resident to the dining room without brushing her bottom teeth. During an interview on 11/20/19 at 12:43 p.m. Staff C confirmed they did not brush the resident's lower teeth. During an interview on 11/21/19 at 8:10 a.m. the DON stated she expected staff to brush the resident's teeth with a.m. cares.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 677	Continued From page 15 3. According to the MDS dated 9/13/19 Resident #14 required physical assistance with bathing. A Care Plan with a problem start date of 3/9/17, documented Resident #4 had a problem related to a self care deficit. The Care Plan included an approach for staff to provide the resident with a whirlpool (w/p) bath, shower or bed bath 2 times a week. Review of an Activities of Daily Living (ADL) flow sheet dated 8/2019, showed staff documented 1 whirlpool bath, shower or bed bath given between the dates of 8/15 and 8/31/19 (16 days). Staff documented the only bath or shower given between those dates had been given on 8/19/19. Review of an ADL flowsheet and ADL Satus sheets dated 9/2019, revealed staff documented 5 baths and/or shower given during the month (rather than 9 baths as scheduled). 4. According to the MDS dated 11/5/19 Resident #20 required physical assistance with bathing. A Care Plan with a problem start date of 6/19/18, documented Resident #20 had a problem related to a self care deficit. The Care Plan included an approach for staff to provide the resident with a whirlpool bath or shower 2 times a week. Review of an ADL flowsheet and Status sheets dated 9/2019, documented the resident received 1 bath/shower the weeks of 9/8 and 9/15 and received no bath/shower between 9/22/19 - 9/30/19. During interview on 11/18/19 at 9:50 A.M., Staff A, Certified Nurse Aid (CNA), reported the facility	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	606 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 677	Continued From page 16 had problems with the w/p tub "forever". She stated approximately 2 weeks ago staff showered the residents in the Beauty Shop shower until that shower quit working and all residents received bed baths for approximately 1 week. Staff A confirmed the only shower in the facility as the Beauty Shop shower. Staff A stated the facility replaced the w/p tub approximately 2 weeks ago. During interview on 11/18/19 at 11:15 A.M., Staff K, facility Maintenance Supervisor, stated there had been a problem with the facility w/p tub between 4/2019 - 10/2019. He stated there had been problems with the door on the tub and the tub leaked. He reported every few weeks nursing staff reported a problem with the tub, he looked at it and got the tub up and running until it completely quit running around 11/4/19. During interview on 11/18/19 at 3:50 P.M., the Provisional Administrator stated the w/p tub had not been in operation for approximately 1 1/2 -2 weeks. She stated during the time the w/p tub had not been working, the residents were showered in the Beauty Shop shower or given a bed bath. During interview on 11/20/19 at 12:30 P.M., Staff C, CNA stated during the time the w/p tub had not worked, the Beauty Shop shower drain had not worked and had been unable to use that shower for approximately 2 weeks. Staff C stated during the time the shower had been down, all residents received bed baths. Staff C stated during the times she assisted residents with a bath or shower, she documented the bath or shower on the resident's ADL flowsheet. During interview on 11/20/19 at 1:05 P.M., the	F 677	Certified Nursing assistants and charge nurses were educated on in the moment documentation on 12-6-19. Charge Nurses have been educated on making sure all documentation is completed before any employee leaves their shift. Facilities whirlpool has been fixed as of 11-4-19. Audit's will be completed daily on bathing X1 week, then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	606 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 677	Continued From page 17 facility Director of Nursing (DON) confirmed the w/p tub had been unavailable between the dates of 10/16/19- 11/4/19. The DON reported the Beauty Shop shower had never been unavailable for the residents use. During telephone interview on 11/20/19 at 1:10 P.M., the facility Corporate Maintenance Supervisor stated the Beauty Shop shower never had a problem with the drain and had never been unavailable for the residents use. During interview on 11/21/19 at 8:55 A.M., the DON stated she expected staff to document a bath given on an ADL flowsheet. She stated she felt because the facility required the use of Agency staff, baths are not always being documented.	F 677	weekly X4 weeks and Monthly X12 months by the DON or their designee. Audits on oral care will be completed Weekly X4weeks, then bi weekly X1 month, and then monthly X12 months to assure adequate oral care is being completed. Any issues with bathing or lack of documentation or issues with oral care will be reviewed with the QA committee. This represents the facilities credible allegation on compliance dated 12-13-19.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure appropriate footwear was worn per the care plan interventions to prevent falls for 1 resident reviewed (Resident #18). The facility reported a census of 21 residents. Findings include:	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18 According to the Minimum Data Set (MDS) assessment, dated 10/30/19, Resident #18 scored 4 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Resident #1's diagnoses included urinary tract infection, multiple drug resistant organism, and Alzheimer's disease. A Fall Scene Investigation dated 7/12/19 at 8:00 p.m. documented the resident found kneeling in front of the recliner. The resident had bare feet. The new intervention included gripper socks at night. An Incident/Accident Report dated 9/1/19 at 10:15 p.m., documented the resident yelled for help and stated she tried using furniture to get to the bathroom and the recliner moved. She said her feet got tangled and staff found her sitting on the floor with her feet under her recliner. A Fall Scene Investigation for the 9/1/19 fall documented the resident had barefeet. The current Care Plan, edited 10/25/19, identified the resident at risk for falls. The interventions included gripper socks at night dated 7/15/19 and try to assure the resident had proper well-maintained footwear, dated 5/16/19. An Incident/Accident Report dated 10/19/19 at 11:35 p.m., documented helped the resident to her bathroom 3 minutes prior, then a Certified Nursing Assistant (CNA) heard a noise and found the resident on the floor of her bathroom. A Root Cause Analysis tool dated 10/19/19 documented the resident had no shoes on and	F 689	All care plans will be reviewed during care conferences by the attendee's and the DON or their designee, all incident reports will be audited by the DON or their designee to assure that appropriate interventions are being put into place and managed correctly. Charge nurses have been educated on 12-11-19 to review care plans weekly to assure correct	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 19 did not wear socks. The root cause of the incident identified as not wearing proper footwear. The tool identified the new intervention to wear appropriate footwear (already on the care plan). During an interview on 11/19/19 2:27 p.m., the Director of Nursing (DON) stated she expected staff to follow the care plan.	F 689	Interventions are in place and being followed. The DON will review any issues with the QA committee. This represents the facilities credible allegation of compliance dated 12-13-19.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (I) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	168468	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 690	Continued From page 20 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to assure perineal care performed in a manner to prevent infection for 2 of 3 residents reviewed (Resident #1 and #8). The facility reported a census of 21 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment, dated 8/17/19, Resident #1 scored 3 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The resident required extensive assistance with toilet use and personal hygiene and had occasional bowel and bladder incontinence. The resident's diagnoses included Alzheimer's disease. The current Care Plan edited 10/25/19, identified the problem urinary incontinence. The interventions included provision of incontinent care after each incontinent episode. During an observation on 11/20/19 at 8:53 a.m. Staff C, Certified Nursing Assistant (CNA) and Staff I, CNA assisted the resident with a.m. cares. Staff walked the resident to the toilet. The resident urinated and had a bowel movement (bm) on the toilet. Staff I wiped resident's anal area of bm 3 times with disposable wipes, then pulled clean wipes out of the packet with the	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165468	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 690	Continued From page 21 same gloved hand and handed to Staff C who wiped the resident's perineal area. During an interview on 11/21/19 at 8:10 a.m. the DON stated staff should change gloves after cleaning bm, before handling wipes to clean the perineal area. 2. According to the MDS assessment, dated 10/5/19, Resident #8 scored 5 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The resident depended on staff for toilet use and personal hygiene and had frequent bowel and bladder incontinence. The resident's diagnoses included Alzheimer's disease. The current Care Plan edited 10/17/17, identified the resident had urinary incontinence. The interventions included providing incontinent care 2 times a day and as needed. During an observation on 11/20/19 at 7:30 a.m. Staff I, CNA and Staff C, CNA assisted the resident. The DON observed. Both staff washed their hands and applied gloves. Staff C used disposable wipes on the resident's bilateral groins and genital area. Staff C changed gloves and used hand sanitizer. Staff turned the resident to her left. Staff C wiped the coccyx and anal area downward (back to front). During an interview on 11/21/19 at 8:10 a.m., the DON stated she expected staff to wash the anal area front to back. She said she noted the staff wiped in the wrong direction when cleaning the resident's anal area. The facility Peri Care Policy and Procedure, dated	F 690	Staff 1, CNA and Staff C, along with all other CNA's have reviewed the incontinence care protocols and have been informed that failure to provide appropriate incontinence care to residents may result in disciplinary actions up to and including termination as of 12-9-19. Peri care audits will be completed randomly to assure appropriate peri care and hand washing is done by the DON or their designee. The DON or their designee will take any issues to the QA committee for review. This	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 690	Continued From page 22 9/26/19, directed while resident in side lying position wipe up the buttock and anal area with a clean surface of the wipe in an upward motion.	F 690	represents the facilities credible allegation of compliance dated 12-13-19.	
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and policy review, the facility failed to have 2 staff on duty as required during a night shift on 8/16/19.	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 725	Continued From page 23 The facility reported a census of 24 residents on 8/16/19. Findings included: Review of a facility Licensed Nurse and Certified Nurse Aide (CNA) schedule dated 8/16/19, revealed 1 LPN and 1 CNA scheduled to work per the facility requirement. During telephone interview on 11/19/19 at 6:55 A.M., Staff H, Licensed Practical Nurse reported he worked alone at the facility during the Friday night hours on 8/16/19. Staff H confirmed he worked a 12 hour shift on 8/16/19 and arrived at work at approximately 6:00 P.M. He stated the day shift nurse handed him a note that stated the night shift Certified Nurse Aid (CNA), called the facility at approximately at 5:45 P.M. and could not come to work her shift at 10:00 P.M. Staff H stated at approximately 6:00 P.M., he called the Director of Nursing (DON), reported the CNA assigned to work the night shift had called in and not coming to work at 10:00 P.M. Reportedly, the DON told Staff H she would call Agency staff to find a replacement. Staff H stated at 9:00 P.M., he called the Agency staffing offices and had been told no one had contacted them to replace the CNA on the night shift. Staff H stated both of the CNA's who worked the evening shift on 8/16/19 had spoken to the DON and told her they could not stay to work the night shift. Reportedly at 10:00 P.M., both of the CNA's who had worked the evening shift on 8/16/19, left the building and Staff H stated he worked alone from 10:00 P.M. on 8/16/19, until the next morning at 6:00 A.M. Staff H stated he tried to call the DON several times and the calls went directly to her voice mail. He stated the Administrator had been getting	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165468	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	606 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 725	Continued From page 24 married that weekend and she had been unavailable and he called the facility Corporate Quality Assurance Nurse and received no answer. During interview on 11/19/19 at 7:10 A.M., the facility Director of Nursing (DON), confirmed she knew of 1 time when a nurse worked alone in the facility,but lacked remembrance of the date. She stated at the time she received the call from Staff H, she instructed him to have one of the CNA's from the evening shift stay to cover the night shift. The DON stated she had not directly spoken to the evening shift CNA's and could not remember if she had been told the CNA's had not been able to stay. The DON stated she received no further calls from Staff H that night. During interview on 11/19/19 at 7:35 A.M., Staff I, CNA confirmed she worked the morning shift on 8/17/19 at 6:00 A.M. Staff I confirmed no CNA's had been in the building from the night shift on 8/16/19 and confirmed Staff H had worked alone. During interview on 11/19/19 at 7:40 A.M., Staff J, CNA, confirmed she worked the morning shift on 8/17/19 at 6:00 A.M. Staff J confirmed Staff H worked alone on the night shift 8/16/19. During telephone interview on 11/19/19 at 8:26 A.M., the facility Administrator in-charge on 8/16/19, stated she had not been aware of any incidents of only 1 staff on duty on a night shift. She stated the DON usually comes in and covers at the times of no CNA available to work. During interview on 11/19/19 at 10:30 A.M., the DON confirmed no CNA had clocked in on the night shift of 8/16/19.	F 725	The policy has been reviewed regarding Employee call in's for coverage by the DON and Administrator. All employees have been educated on the policy and the requirements regarding call in's. The DON or their designee will be notified of all call in's to the facility so the DON or designee can address appropriately. The DON or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 725	Continued From page 25 A facility Employee Coverage for Call-Ins policy, with a revised date of 3/1/08, revealed the following: In the event an employee calls off their shift, an employee from the previous shift will be held over until coverage can be found and is in the building.	F 725	will review any issues regarding the call in policy with the QA committee. This represents the facilities credible allegation of compliance dated 12-13-19.	
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on employee file review, policy review and staff interview, the facility failed to ensure Certified Nurse Aides completed 12 hours of in-service education per year for 3 of 5 employee files reviewed (Staff A, E and F) and failed to complete an annual job performance evaluation for 1 of 5 employee records reviewed. The facility reported a census of 21 residents. Findings included: 1. An Active Employee list dated 11/18/19 revealed Staff A's hire date of 10/29/18. Staff A's in-service transcript revealed she completed 6 hours of training for year since her anniversary date of hire. 2. An Active Employee list dated 11/18/19, revealed Staff E's hire date of 5/9/09. Staff E's	F 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 730	Continued From page 26 in-service transcript revealed she completed 6.25 hours of training for the year since her anniversary date of hire. 3. An Active Employee list dated 11/18/19, revealed Staff F's,hire date of 9/13/17. Staff F's in-service transcript revealed she completed 6.75 hours of training for the year since her anniversary date of hire. 4. Review of Staff G's Employee Job Performance Evaluation revealed a review date with the employee of 2/21/18 and had no current performance evaluation. During interview on 11/20/19 at 11:16 A.M., the facility Director of Nursing (DON) stated she had understood in-service hours were for the calendar year and not the year from and employees hire date. She confirmed Staff G had been scheduled whenever necessary (PRN) and reported a facility Human Resource staff member had told her employees who worked PRN, had not required a job performance evaluation. Review of a facility Employee Handbook (no date) included documentation for nursing staff in-service training and the requirement to attend 12 hours per year. The policy documented staff performance would be reviewed at regular intervals by a Supervisor and may counsel a staff member to develop strengths and suggest areas of improvement.	F 730	Staff education for all employees will be reviewed on their hire date by the DON or their designee. Staff who fail to have their 12 hours of education by their 12 month period will not be able to work on the floor until the education has been completed. Certified Nurse Aides have been educated on the mandatory 12 hours of continuing education that is due by their hire date, and have signed off that all education needs to be completed as soon as possible. The DON or their designee will be auditing all education until all certified Nurse Aides have completed all of their education. The DON or their designee will review any issues with the QA committee. This represents the facilities credible allegation of compliance dated 12-13-19.	
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality	F 868		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 868	Continued From page 27 assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on review of Quality Assurance (QA) committee sign in sheets and staff interview, the facility failed to assure the required members attended 1 of 4 meetings. The facility reported a census of 21 residents. Findings include: The Quarterly QA Minutes sign in sheet dated 5/17/19 showed the Minimum Data Set assessment Coordinator, the Medical Director, and the Administrator in attendance. An undated facility policy documented the QA committee would consist of the Director of Nursing (DON), Medical Director, Administrator, and at least 2 other members of the staff. During an interview on 11/21/19 at 9:15 a.m. the DON and Interim Administrator both stated they were not at the facility in May 2019 for the QA meeting, but confirmed the required committee	F 868	The facilities policy and procedures for QA have been reviewed by the Administrator and their designee. QA meetings will be audited quarterly to assure 5 members are present. The Administrator or their designee will review any issues with the QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	606 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 868	Continued From page 28 members were not present (per the sign in sheet).	F 868	committee. This represents the facilities credible allegation of compliance dated 12-13-19.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	608 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 880	Continued From page 29 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to assure appropriate infection control interventions for 3 of 13 residents reviewed (Resident #3, #13, and #18). The facility reported a census of 21 residents. Findings include:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165468	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 880	Continued From page 30 1. According to the Minimum Data Set (MDS) assessment, dated 9/4/19, Resident #3 demonstrated long and short term memory problems and severely impaired skills for daily decision making. The resident depended on staff for toilet use and personal hygiene. During an observation 11/19/19 at 8:42 a.m. Staff A, Certified Nursing Assistant (CNA) and Staff M, CNA provided care. Staff A placed a stuffed animal the call light was tied to on the floor at her feet. Staff M placed the washcloth from the resident's forehead in the sink and turned the water on. Staff rolled the resident to her right and Staff M wiped her anal area and buttocks with disposable wipes. Staff M then handed the packet of wipes with both hands and placed a new incontinent pad before removing her gloves and using hand sanitizer. When finished Staff A picked the stuffed animal up off the floor and placed it on the residents abdomen. Staff M removed the washcloth laying in the sink and placed it on the residents forehead. Staff M picked up the packet of wipes and tucked it under her arm pit before placing it in a basin with other supplies. During an interview on 11/21/19 at 8:10 a.m. the Director of Nursing (DON) stated staff should not place items on the floor. She stated staff should remove gloves after pericare before touching items in the environment. 2. According to the MDS assessment, dated 10/17/19, Resident #13 scored 4 on the BIMS, indicating no cognitive impairment. The resident's diagnoses included peripheral vascular disease.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 880	Continued From page 31 The current Care Plan, edited 10/27/19, identified the resident had altered skin integrity related to surgical incision. The interventions included to provide treatment per protocol or physician's order. During an observation on 11/20/19 at 8:58 a.m. a plastic container with supplies sat on the resident's bed (with no barrier) and the resident's leg on a bed pad. Staff L, Registered Nurse (RN) washed her hands and applied gloves. Staff L removed the dressing to the area of the right great toe amputation and squirted saline on the dressing stuck to the resident's skin. Staff L put the dressing in the trash can and changed gloves with no hand hygiene. She retrieved dressing supplies from the plastic container and sat the wound cleanser on the bed pad. She mixed normal saline (NS) and hydrogen peroxide (H2O2) and poured over the wound and used a gauze pad to wipe the area. She used a solution and packed the wound and applied a dressing. Staff L removed her gloves and carried the container with supplies to a cart in the hall then used hand sanitizer. At 8:45 a.m. the plastic container (with the supplies) sat on a chair in the resident's room with no barrier and the lid sat on the resident's bedside stand with no barrier. Staff L removed the dressing from the resident's left leg dated 11/18/19. Staff L cleaned the wound without changing her gloves. Staff L removed more gauze pads from the supplies in the container, then changed gloves with no hand hygiene and cleaned the area again. During an interview on 11/21/19 at 8:10 a.m., the DON stated she expected hand hygiene between glove changes. She expected staff to change	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 880	Continued From page 32 gloves after dressings were removed, before cleaning the wound. She did not think a barrier was necessary if the supplies were in a plastic tote. The Interim Administrator/Infection Control Nurse stated if the tote went in and out of the room it should be put on a barrier, unless staff disinfected it. The undated facility Wound Care Dressings policy directed to put gloves on and remove old dressings, discard in a plastic bag along with gloves. Put on new gloves. If added supplies were needed from treatment cart, the nurse would remove gloves, and wash hands before obtaining needed supplies. The facility Hand Washing Policy and Procedure dated 9/26/19 directed to wash hands before gloving and after gloves were removed. According to the Centers for Disease Control (CDC) and Prevention 'multiple opportunities for hand hygiene may occur during a single care episode. The clinical indications for hand hygiene included immediately after glove removal. The CDC document read: Always clean your hands after removing gloves. Dirty gloves can soil hands. 3. According to the MDS assessment, dated 10/30/19, Resident #18 scored 4 on the BIMS, indicating severe cognitive impairment. The resident's diagnoses included urinary tract infection, multiple drug resistant organism, and Alzheimer's disease. A facsimile (fax) dated 11/7/19 notified the physician the lab reported the resident had	F 880	All staff have completed a Mandatory Infection Control and Prevention In service with Relias Training on 11-9-19 or after. Random audits will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166458	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	606 EAST FOURTH STREET SUTHERLAND, IA 51058

(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 880	Continued From page 33 positive results for Clostridium Difficile (c-diff) (bacterial inflammation of the colon) and had recently been treated for the same. The physician ordered Vancomycin for 10 days. During an observation on 11/19/19 at 1:39 p.m. a cart outside the residents door contained supplies. There was no sign indicating precautions. During an interview on 11/19/19 at 1:44 p.m. Staff M, CNA stated the resident was on contact precautions. The facility Contact Isolation Precaution policy included a stop sign would be posted on the door of the room. During an interview on 11/20/19 at 11:32 a.m., the DON stated they had a separate C-diff policy. It included the use of signage on the door. She confirmed they had no sign on the door. A policy regarding c-diff dated 9/26/19 included posting signage regarding isolation precaution.	F 880	completed with Infection Control and Prevention weekly X1 week, and bi weekly X1 month and monthly X12 months. In the moment teaching will occur randomly when needed by the DON or their designee. All staff have been educated on signage for isolation precautions this will be audited as needed. Hand washing policy and procedure has been reviewed by the DON or their designee and random audits will occur. Dressing change audits will be completed randomly by the DON or their designee. The DON or their designee will review any issues with the QA committee. This represents the facilities credible allegation of compliance dated 12-13-19.	