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 _____	C 08/31/2020

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 Corrected date 9.20.20 Investigation of complaint #92375-C and a Covid-19 focused survey completed 8/20-31/20 resulted in the following deficiencies. Complaint #92375-C was substantiated. (See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.)	F 000		
F 689 SS=G	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 observation, record review, and staff interview, the facility failed to provide adequate supervision to prevent accidents for 1 of 4 residents reviewed (Resident #4). The facility reported a census of 26 residents. Findings include: According to the Minimum Data Set (MDS) assessment, dated 7/1/20, Resident #4 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident depended on staff for transfers, and diagnoses included a stroke. The Care Plan revised 3/11/20, identified the resident at risk for further functional decline in	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jenny Kabnick | TITLE: Administrator | (X6) DATE: 9/20/2020

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

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F 689	Continued From page 1 activities of daily living (ADL's) performance related to mobility impairment and obesity. The interventions included transferring with assist of 2 and a sit to stand lift during the day shift only, and transfer with the total mechanical lift and assist of 2 during the evening and overnight shift. An Incident/Accident Report dated 8/18/20 at 9:05 a.m., documented during a transfer from the bed to the wheelchair, the 600 pound total mechanical lift tipped over with the resident in the air, hitting her head on the sink and the lift landed on top of her. The Nurse's Notes dated 8/18/20 at 9:00 a.m. documented during a transfer from bed to the wheelchair with 2 assist and the total mechanical lift, the lift tipped over sideways with the resident in the air and fell. The resident hit her head on the sink vanity and the lift fell on top of her. No visible injuries noted, but unable to obtain blood pressure. The resident transported to the hospital at 9:30 a.m. to assess potential injuries. The resident complained of head and back pain before transport. At 1:30 p.m. the resident returned to the facility with orders for neuro checks every 2 hours until 8 p.m., then every 4 hours until follow up Computed Tamography (CT) scan the following day. An Emergency Department (ED) Physician Note dated 8/18/20 documented the resident presented following a fall at the nursing facility while being transferred in the mechanical lift and the lift tipped over. The resident stated her head hit the sink and she had pain in her arm. The character of symptoms described pain and tingling and the degree 10 out of 10. The relieving factor none.	F 689		

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F 689	Continued From page 2 The impression of the CT scan of the head included a focal hyperdensity at the superior margin of the encephalomalacia (softened area of brain) which represented a small focus of acute hemorrhage or calcification. The impression included traumatic hematoma of the right forearm, acute head injury without loss of consciousness, and pain in the right arm. Follow up included repeat CT scan the following day. The ED report dated 8/18/20 documented the resident received a head injury. It did not appear serious at the time. Headaches and vomiting were common following a head injury. After injuries such as this most problems occurred within 24 hours, but side effects could occur up to 7-10 days after the injury. A CT scan done 8/19/20 and compared to 8/18/20 revealed a 4 mm hyperdense focus of the right frontal lobe superior to the known encephalomalacia less pronounced than prior CT suggesting interval decrease/improvement in tiny focus of intraparenchymal hemorrhage (bleeding within the brain). Additional short term follow-up CT could be obtained in 1 week. A Patient Care Report dated 8/18/20 during transfer back to the facility documented the resident's chief complaint headache and swelling, with the headache improved, and swelling still present. The Nurse's Notes dated 8/20/20 at 11:50 p.m. documented the resident reported pain from the fall, otherwise no other noted injuries. In an Investigation Statement Summary dated 8/18/20 Staff B, Certified Nursing Assistant (CNA)	F 689		

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F 689	Continued From page 3 documented during a transfer to the wheelchair the hoyer (total mechanical lift) tipped on another employee and herself. The statement included she determined the cause of the incident due to hoyer transfer on carpet. In an Investigation Statement Summary dated 8/18/20 Staff A, CNA documented the hoyer tipped. She determined the cause of the incident hoyer transfer on carpet, hard to move on carpet. In an Investigation Statement Summary dated 8/18/20 Staff C, documented she walked in after the incident. She documented the cause of the incident the carpet with a question mark. In an Investigation Statement Summary dated 8/18/20 Staff E, CNA documented staff called for help. When she got to the resident's room the resident laid on the floor hooked up to the hoyer tipped on it's side. She determined the cause of the incident carpet with hoyer caused difficulty to maneuver. In an Investigation Statement Summary dated 8/18/20 Staff F, documented when called to the resident's room, the resident laid on the floor with the hoyer. She determined the cause of the incident lack of space to move and carpeted floors. In an Investigation Statement Summary dated 8/18/20 Staff D, Licensed Practical Nurse documented she was called to the resident's room because the hoyer lift tipped over during a transfer from the bed to her wheelchair. The resident laid on the floor with her head against the sink vanity and the hoyer lift laying on top of her. The statement documented no visible open injury,	F 689		

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F 689	Continued From page 4 but an egg sized red area to the back of the head. The resident complained of pain to her head and back. She determined the carpeting in the room made transfers extremely difficult and dangerous, and the room too small for the resident. During an observation 8/25/20 at 8:40 a.m. Staff C, demonstrated how the lift (used in the transfer with the resident) worked to open and close the base (the lift was out of service and the wheels were removed from the lift). She said the back wheels of the lift could lock but that did not lock the base open. During an interview on 8/24/20 at 10:20 a.m. Staff A, Certified Nursing Assistant (CNA) stated she assisted with the transfer when the lift tipped over. She said Staff B, CNA operated the lift. They had the resident (raised) up. The back wheels of the lift were locked and the base spread to it's widest point. Staff A stated she tried to get one of the resident's legs on each side of the bar and the resident facing Staff B so they could transfer the resident to the wheelchair. Staff A stated they did not have enough room to maneuver and the room had carpet. She said the base did close when the lift tipped. She said she told the Administrator numerous times the resident had too much stuff to share a room, and she told the Administrator the lift nearly tipped prior to this incident a number of times. She said no one ever did anything about it. She said it was unsafe to transfer the resident in that environment. During an interview on 8/24/20 at 12:19 p.m. the Director of Nursing (DON) stated being aware staff felt doing a lift (transfer) in the tight quarters of the room and with the carpet made it unsafe.	F 689		

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F 689	Continued From page 5 During an interview on 8/24/20 at 2:20 p.m. Staff B stated she operated the lift when it tipped over with the resident. She said they needed a big amount of space to pull the lift away from the bed, and it was extremely difficult on the carpet. She said she told the Administrator multiple times (the transfer) was not safe on the carpet. She said they pulled the resident away from the bed and turned her. They got her leg over and the lift toppled over. She said the resident had so much stuff. She told the Administrator about the safety concerns. During an interview on 8/24/20 at 3 p.m. Staff C, CNA stated she had assisted with transfers with the total mechanical lift in the resident's previous room (the resident moved after the incident). She said with the resident's and the roommate's stuff they had little room to maneuver and extreme difficulty moving the lift on the carpet. She said she told the Administrator multiple times it was unsafe transferring the resident (with the lift) for those reasons. She said the Administrator said the resident had to have a roommate. During an interview on 8/24/20 at 3:25 p.m. the Housekeeping Supervisor stated they had talked about putting the resident in a room with linoleum to aide in transfers, or a room by herself, but the Administrator said they could not. The 200 hall had linoleum floors, but was the quarantine hall and the resident had to have a roommate. During an interview on 8/25/20 at 10:45 a.m. the Administrator stated they did not feel the incident with the lift was a lift malfunction. She said they had that lift since July 2018, and they use them in other facilities without problems. She didn't know	F 689		

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F 689	Continued From page 6	F 689		

what caused the incident, but thought maybe the room was too crowded. She said the resident wanted a private room and could not have one. She said they did change the resident's roommate to a resident who slept in the recliner and did not have a bed for more room (8/2/20). She said after the incident they were going to remove extra stuff from the room (but the resident moved to the quarantine area with no carpet, in a room by herself after evaluated in the ED).

During an interview on 8/25/20 at 10:58 a.m. Staff B stated after the resident had a change in roommates (with resident who slept in the recliner) it remained too crowded and she still felt unsafe with the lift transfers. She said too crowded and hard to maneuver on the carpet. She said she reported her concerns to the Administrator after the move.

During an interview on 8/25/20 at 11:04 a.m. Staff C stated after the room change with the resident who slept in the recliner she still felt the room too crowded for safe transfers and at that point she went to the DON.

During an interview on 8/25/20 at 11:12 a.m. the Housekeeping Supervisor stated the resident had a change of roommate with a resident who slept in the chair, but it did not solve the problem. Even without the other bed in the room they had too much in the room and in the way. She said the concern for safe transfers remained. She said they fought really hard for the resident to have her own room.

During an interview on 8/25/20 at 11:18 a.m. the DON stated after the resident had a change in

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F 689	Continued From page 7 roommates with a resident who slept in the recliner, staff continued to voice concern for the resident's transfers, citing it was too crowded and difficult on the carpet. She said she had numerous conversations with the Administrator about the concerns but she said they could do nothing. They were not using the sit to stand lift for the resident. During an interview on 8/25/20 at 11:56 a.m. the resident stated all she knew was they picked her up with the lift and it tipped over. She said they did not have enough room to get around and the carpet may have been a problem. She said she did hit her head and it remained sore. During an interview on 8/25/20 at 1:10 p.m. Staff D stated she worked the day of the fall. She said the CNA's told her they were trying to get the resident's legs around the bar and the lift tipped. Staff D called 911 because the resident hit her head and it was a significant fall. The resident reported being very uncomfortable and complained of her back and head hurting. She said due to the resident's size the lift did not roll very well on the carpet. The CNA's talked daily about the lift transfers not being safe for the resident because it was very cramped. She said they needed more space for a safe transfer. She said she did relay this to the DON. During an interview on 8/26/20 at 8:20 a.m. a customer service representative of the lift company stated she had never heard of one of these lifts tipping over. She questioned if there were other complicating factors.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		

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F 692	Continued From page 8 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete an accurate nutritional assessment, weigh a resident per facility protocol, or identify a significant weight loss for 1 resident reviewed (Resident #3). The facility reported a census of 26 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 6/4/20, Resident #3 admitted to the facility on 5/28/20 and scored 13 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident depended on staff assistance with eating. The resident's	F 692		

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diagnoses included paraplegia (paralysis of the legs and lower body) and multiple sclerosis. The MDS documented the resident weighed 113# with no weight loss of 5% in 1 month or 10% in 6 months.

A hospital History and Physical printed 5/28/20 documented the resident appeared very thin with a Body Mass Index (BMI) of 16, however the note also documented they had no weight or height on file to calculate the BMI. A hospital Discharge Summary dated 5/28/20 also lacked the resident's weight and height.

The facility Resident Weights record documented the resident weighed 112.2# on 5/28/20, and 106.6# on 6/9/20 a 5.6# or a .0499 (5%) significant weight loss in less than 2 weeks. The clinical record lacked identification of the loss, and no other weights were recorded before the resident discharged on 7/2/20.

The Care Plan created 6/18/20 (after the weight loss) identified the resident at risk for less than body requirements related to refusing to eat at times. The interventions included the resident could eat finger foods on her own, assist as needed with other food options, regular diet, and refused to eat meals at times due to beliefs of what was good for her body. The Care Plan identified a self care deficit related to paralysis. The interventions included a monthly weight.

During an interview on 8/24/20 at 3:50 p.m. the Director of Nursing stated she could not find a nutritional assessment in the resident's record, and found no notification of the resident's physician or family of the weight loss.

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F 692	Continued From page 10 The facility provided the following documentation from the dietician via email 8/26/20: a. 5/30/20 Admit assessment. Wt 107#. She consumed a regular diet. Oral intake (PO) = refused-50-100% at some meals. She took Ensure 3 times a day (TID) for weight management. Would offer calories as able. Would monitor weight and intakes ongoing as adjusted to the facility and adjust approaches as needed for weight management. b. 6/25/20 Admit assessment. Wt 107#. She consumed a regular diet. Oral intake (PO) = refused-50-100% at some meals. She took Ensure 3 times a day (TID) for weight management. Would offer calories as able. Would monitor weight and intakes ongoing as adjusted to the facility and adjust approaches as needed for weight management. The Diet and Nutrition Record for June 2020 showed the resident refused 12 meals and ate 0 for 4 additional meals. The record lacked documentation of the resident receiving a supplement. The documentation for 5/30 and 6/25/20 appeared identical, did not reflect the resident's admission weight accurately and failed to identify the weight loss. The clinical record lacked documentation of the residents likes and dislikes, or food intolerances. The record lacked documentation of offering a substitute for food not eaten. An Interdisciplinary Discharge Summary documented the resident on a regular diet, and had many food dislikes making serving difficult. The note did not indicate the use of supplements or weight loss.	F 692		

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F 692	Continued From page 11 In an email dated 8/26/20 the facility Dietician wrote she went off the weight provided to her by the Dietary Supervisor (DS). It had been confusing at times collecting data remotely with staff taking pictures of data to scan to her because there were no electronic charts to review. She added if they knew of a better way to handle delivery of correct and timely data for the assessments, please advise so the needs/requirements were met as intended. During an interview on 8/27/20 at 8:04 a.m. the resident stated she received Ensure 2 times a day, and may have received 3 times if she could not eat what they had on the menu. She informed someone at the facility of foods she could not eat. She stated she lost 6# in the 1st 2 weeks at the facility and they never weighed her again. During an interview on 8/27/20 at 11:01 a.m. the Dietician stated she had no other nutrition assessment on the resident. She said she thought she got the wrong information. She said the DS collected information on the residents likes, dislikes, and intolerance's. She said at least the previous DS did, she didn't know about the current DS. She said she did not know the resident had a weight loss. If she had she would have assessed the situation and most likely tried to add more calories. She said what she had in the assessment, the facility provided her. During an interview on 8/31/20 at 8:58 a.m. the DS stated she usually provided the Dietician with information on the residents including weight and diet. She didn't know what happened with the	F 692		

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F 692	Continued From page 12 inaccurate weight on the admit nutrition assessment. She said she did not recall the resident showing a weight loss or being on Ensure. She said they would need a doctor's order for Ensure (The Physician Order Report 5/30-6/30/20 directed a regular diet and listed no supplements). She said she would look for additional information and forward if found. The facility Weight Management policy revised 7/30/19 documented all residents would have their nutritional needs assessed and monitored at a minimum of monthly/or more often as deemed necessary to follow up with identified concerns. Residents identified with a significant loss would have weight measured weekly. Newly admitted residents would have a weekly weight for 4 weeks to determine a baseline and monitor for risk. If a discrepancy of 3 or more pounds gain/loss noted from the previous weight the resident would be re-weighed. If the re-weigh did not establish a variance then the re-weigh would be documented as the recordable weight. Should the variance be the result of significant weight loss, the consultant dietician, physician, and family would be notified of the significant change.	F 692		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		

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	165458	A. BUILDING _____ B. WING _____	C 08/31/2020

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 812	Continued From page 13 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to serve food in accordance with professional standards for food service safety during 1 meal observation. The facility reported a census of 26 residents. Findings include: During the noon meal service on 8/20/20 at 11:40 a.m. the Dietary Supervisor (DS) wore gloves touching plates, utensils, the steamer top, and using the same gloved hands to pick up the bread and butter and place it on the resident's plates. She did this repeatedly throughout the meal service. She held the meat on the plate with gloves that touched other items while cutting with a knife. She did this through a portion of the service, then started using a fork to hold the meat while cutting. During an observation of the noon meal service on 8/24/20 the DS wore gloves, but used utensils to serve ready to eat food. During an interview on 8/25/20 at 1:20 p.m. the Dietary Supervisor said on 8/24/20 she used utensils instead of touching the food with her	F 812		

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F 812	Continued From page 14 gloved hands, when she thought more clearly. The undated facility dietary policy for the Use of Gloves directed gloves would be used only when appropriate. The procedure included single use gloves should be used for only 1 task such as working with ready to eat foods and discarded when damaged, soiled or when an interruption occurred in the operation.	F 812		
F 880 SS=E	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:	F 880		

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F 880	Continued From page 15 (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; (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:	F 880		

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F 880	Continued From page 16 Based on observation, record review, and staff interview, the facility failed to implement infection control interventions during screening to enter the facility, for residents in isolation, during meal service, and for 1 resident with a catheter (Resident #1). The facility reported a census of 26 residents. Findings include: 1) During an observation on 8/20/20 at 9:10 a.m. Resident #6 had a sign on the door indicating Airborne Precautions. The resident's door remained open. Resident #4 and Resident #8 had signs on their doors reading Airborne Precautions. At 9:57 a.m. the door to Resident #6's room remained open. At 10 a.m. Resident #4 sat in the doorway of her room with no mask on. During observation on 8/24/20 at 8:15 a.m. Resident #7 sat in the recliner in her room with the door open. Resident #6's door remained open. During an interview on 8/24/20 at 12:07 p.m. the Director of Nursing stated they encouraged resident's on Airborne Precautions keep doors to the rooms closed. 2) During entry into the facility 8/24/20 at 8:15 a.m. Staff G, Housekeeping took surveyor's temperature, touching the thermometer to the forehead. Staff G did not ask about symptoms and laid the thermometer by the screening log and walked away. During entry into the facility on 8/25/20 at 7:50 a.m. Staff H, Housekeeping took surveyors	F 880		

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F 880	Continued From page 17 temperature pressing the thermometer to the forehead. Staff H put the thermometer down, asked the screening questions, directed use of hand sanitizer and walked away without cleaning the thermometer. During an interview on 8/24/20 at 12:07 p.m. the Director of Nursing stated she would expect staff to disinfect the thermometer if it touched the forehead. 3) During meal service on 8/20/20 starting at 11:40 a.m. Staff I, Housekeeping adjusted her facemask then took a resident's lunch tray to their room without performing hand hygiene. Staff F, Certified Nursing Assistant (CNA) touched her mask and her hair, then took a resident their meal tray without performing hand hygiene. During meal service 8/24/20 starting at 11:35 a.m. Staff I, Housekeeping took a tray to Resident #4's room. She stopped and put on an N95 mask (had a surgical mask on). She already had gown, gloves and a shield on. The door to the resident's room open. She removed the gown and gloves before exiting the resident's room. She removed the N95 and put a surgical mask on, leaving the N95 on the isolation container. She continued to wear the face shield without disinfection, and did not shut the door to the room. At 11:52 a.m. Staff J, Laundry went into Resident #8's room which had a white sign reading Airborne Precautions. She wore a gown, surgical mask, and goggles. She left the room wearing the same PPE, filled a water pitcher, and went back in the room. When she exited the room again she continued to wear the same PPE. She shut the door to the room and applied gloves without performing hand	F 880		

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F 880	Continued From page 18 hygiene. During an interview on 8/24/20 at 12 p.m. the DON confirmed Resident #8 on Airborne Precautions. The CDC Strategies for Optimizing the Supply of Facemasks revised 6/28/20 documented the extended use of facemasks is the practice of wearing the same facemask for repeated close contact encounters with several different patients, without removing the facemask between patient encounters. HCP should take care not to touch their facemask. If touched or adjusted they must immediately perform hand hygiene. The facility Covid 19 Patient Protocol created 5/1/20 directed to perform hand hygiene, then put on clean gloves upon entry to the resident room or care area. Remove and discard gloves when leaving the room or care area, and immediately perform hand hygiene. Wear a clean isolation gown upon entry into patient room or area, and discard the gown before leaving the patient care area or room. Disposable respirators should be removed and discarded after exiting the resident's room and or care area and closing the door. Put on eye protection upon entry to the room or care area, and remove eye protection before leaving the resident room or care area. Reusable eye protection must be cleaned and disinfected prior to re-use. 4) According to the Minimum Data Set (MDS) assessment, dated 6/19/20, Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required extensive assistance with toilet use and had an indwelling urinary catheter. The resident's	F 880		

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F 880	Continued From page 19 diagnoses included urinary tract infection (UTI). The Care Plan created 4/30/20, identified the resident with an indwelling suprapubic catheter. The goal included the resident would have the suprapubic catheter care managed by not exhibiting signs of infection. A Patient Encounter dated 6/25/20 documented the chief complaint follow up UTI. The resident with paraplegia with a history of UTI's seen for follow up of UTI on Levaquin (antibiotic), reports increased drainage from suprapubic catheter site. A culture taken from the catheter site exudate 6/26/20 resulted in treatment for cellulitis with Augmentin 875 mg 2 times a day for 7 days, and Ertapenum 1 gram intramuscular daily for 7 days. During an interview on 8/20/20 at 9:40 a.m. the resident laid in bed with the catheter bag hanging from the bed frame. The resident stated staff did not clean the suprapubic catheter site correctly. During an observation on 8/24/20 at 2 p.m. Staff K, Certified Nursing Assistant (CNA) washed her hands and donned gloves. Staff K wiped from the resident's abdomen toward the catheter tubing, and wiped several times at the insertion site without turning the wipe. During an interview on 8/25/20 at 2:40 p.m. the DON stated staff should start at the catheter insertion site and wipe away from it, not toward the catheter. She said staff should not wipe several times with the same side of the cloth.	F 880		
F 885 SS=E	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii)	F 885		

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F 885	Continued From page 20 §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to inform residents, their representatives, and families of those residing in facilities by 5 p.m. the day following the occurrence of a single confirmed infection of Covid-19 of residents or staff. The facility reported a census of 26 residents. Findings include: During an interview on 8/20/20 at 9:00 a.m. the	F 885		

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F 885	Continued From page 21 Director of Nursing stated they had a staff member test positive for Covid-19. She did not know if they notified resident's families of the positive case. A form received from the Administrator on 8/25/20 and dated 7/21/20 documented notification of residents and family of a positive staff member for Covid-19. The form lacked family notification for 14 residents, noting self by their line. The current resident roster showed 4 of the residents in the facility on 7/21/20 were no longer residents of the facility. Each of the other 10 residents had a contact listed on their face sheet. During an interview on 8/25/20 at 12:18 p.m. the Administrator stated a staff member's husband tested positive on the 7/20/20 and the staff member 7/21/20. She notified residents and family. She said if the resident's were their own Power of Attorney (POA) they did not have to notify their family. During an interview on 8/25/20 at 3:19 p.m. Resident #4's family member stated she did not receive notification of any staff or resident testing positive for Covid-19. The facility Covid 19 patient Protocol created 5/1/20 documented the facility would contact residents, resident families, staff and primary care provider of all positive test results by 5 p.m. the following business day post notification.	F 885		

Pearl Valley Rehab - Sutherland
506 East fourth st.
Sutherland, Iowa 51058
Phone: 712-446-3857

Facility ID #165458

Provider's Plan of Correction
Date Survey Completed: August 31, 2020

F 000: Initial Comments:

The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies by Pearl Valley Rehab - Sutherland. To remain in compliance with State and Federal regulations, the facility has taken or will take the following actions set forth in this plan of correction.

F689-

facility failed to provide adequate supervision to prevent accidents for 1 of 4 residents reviewed.

The facility does and will continue to provide adequate supervision for the safety of dependent residents during transfer with mechanical lift.

Facility staff have been educated on proper mechanical lift transfer per facility policy. Facility will perform random audits of staff transfer techniques weekly x4 weeks, then to biweekly x 4 weeks, then monthly x1 month and quarterly for the remainder of the year. All findings to be submitted through quarterly QA and QAPI for further system improvement implementation.

F692-

facility failed to complete an accurate nutritional assessment, weigh a resident per facility protocol, or identify a significant weight loss for 1 residentThe facility does and will continue to monitor and implement appropriate weight loss assessment and nutritional interventions. Facility clinical staff have been educated on the policy for weight monitoring and weight loss intervention implementation.

Facility will perform random monthly audits of staff transfer techniques of resident weights and implementation of dietary interventions. All findings will be submitted through quarterly QA and QAPI for further system improvement implementation.

F812-
facility failed to serve food in accordance with professional standards for food service safety during 1 meal observation.
The facility does and will continue to provide professional practices for safety with food handling.
Dietary staff have been educated regarding facility policy for safety with food handling and glove use.
Facility will perform random weekly audits of safety with food handling and glove use. Weekly x 4 weeks, Biweekly x4 weeks, monthly x1 month and then quarterly through remainder of the year.
All findings to be submitted through quarterly QA and QAPI for further system improvement implementation.

F880-
the facility failed to implement infection control interventions during screening to enter the facility, for residents in isolation, during meal service, and for 1 resident with a catheter.
The facility does and will continue to provide appropriate infection control practices with catheter cares.
Facility clinical staff have been educated on the proper procedure for catheter cares to prevent infection. Facility staff have watched the assigned videos per the direction of 2567 related to injection prevention due to covid 19.
The facility will perform random weekly audits of catheter cares. Weekly x4, biweekly x 4 weeks, monthly x1 and then quarterly. All findings will be submitted through quarterly QA and QAPI for further system improvement implementation.

F885-
facility failed to inform residents, their representatives, and families of those residing in facilities by 5 p.m. the day following the occurrence of a single confirmed infection of Covid-19 of residents or staff.
The facility does and will continue to report positive covid 19 test results in a staff or resident to the appropriate staff, resident representatives and residents.
Facility Administrator and DON have been educated on the requirement of reporting positive covid 19 test results in a staff or resident to the staff, residents and resident representatives by 5pm the following business day after confirmation of results.
Facility will perform random weekly audits of family, staff and resident representatives notification of positive covid 19 test results. Weekly x4 weeks, biweekly x4 weeks, monthly x1 and then quarterly. All findings to be submitted through quarterly QA and QAPI for further system improvement implementation.