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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 10/26/17 An investigation was conducted regarding facility reported incidents 70733-I and 70130-I and complaint 69940-C. Facility reported incidents 70733-I and 70130-I and complaint 69940-C were substantiated.	F 000		
F 223 SS=D	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and family and staff interviews, the facility failed to ensure all residents remained free from abuse (Resident #2). The sample consisted of 10 residents and the facility reported a census of 50 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 8/8/17, Resident #2 had diagnoses that included psychotic disorder,	F 223		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa Vanderbeck	Administrator	10/26/17

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 223	Continued From page 1	F 223		

schizophrenia and intellectual disabilities. The MDS indicated the resident displayed severe cognitive impairment, was independent for transfers, ambulation (walking), and toilet use, and required supervision by staff for dressing and personal hygiene. The MDS indicated the resident exhibited symptoms of delirium, behavior symptoms that included verbal behaviors directed toward others, and other behavioral symptoms not directed towards others that occurred from 4 to 6 of the 7 days that preceded the assessment. A Level II Pre Admission Screening and Resident Review (PASRR) completed 4/26/15 identified the resident had diagnoses that included schizophrenia, paranoid type, and intellectual disability, and directed the staff to provide a behavioral-based treatment plan, with ongoing evaluation of the effectiveness of psychotropic medications on the targeted symptoms.

The nursing Care Plan identified and initiated on 12/15/15, the potential for the resident to express verbally aggressive behaviors related to schizophrenia. The Care Plan included and directed the staff to:

1. Monitor behaviors, report and document observed behavior and attempted interventions.
2. When the resident is agitated, intervene before agitation escalates.

Another Care Plan problem, initiated on 8/8/17, indicated the resident had the potential for physical violence related to repetitive statements. The Care Plan included and directed the staff to:

1. Observe resident for physical violence threats, educate resident and other residents regarding non-use of physical violence.

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F 223	Continued From page 2 2. Separate the resident from Resident #1. On 8/31/17 at 2:20 p.m., Staff F, registered nurse (RN), stated after Resident #1 struck Resident #2 on 8/8/17, Resident #2 said his vision was blurred and had 2 small skin tears. The skin tears measured 1 centimeter (cm) sized or less, on the skin below the eye and a broken blood vessel in the sclera (white portion of the eye). The bleeding stopped once the nurse cleansed the area. The resident refused a medical evaluation and was upset at the time. The event was unwitnessed by staff and occurred in an area where residents had gathered after the supper meal. During an interview on 8/31/17 at 4:05 p.m., Staff D, certified nursing assistant (CNA) and certified medication aide (CMA) stated he worked the evening shift (2 p.m. to 10 p.m.) on 8/8/17. Staff D stated he did not witness the altercation between the 2 residents and Resident #2 usually went to the back nurses station after meals and waited there for the smoking break. Staff D stated Resident #2 would talk to himself but never caused problems with the other residents. Staff D stated he was not aware of any behavioral problems with Resident #1. During an interview on 8/30/17 at 2:28 p.m. the resident's responsible party stated she was notified of the 8/8/17 incident that evening. The responsible party stated she felt the decision about whether or not the resident required additional medical care should not have been left to the resident, who couldn't have understood whether or not the injury was serious due to his intellectual disability. The responsible party stated her first observation of the injury was 5 or	F 223		

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F 223	Continued From page 3 6 days later when there was a bruise around the eye and his eye remained blood shot. The resident told her another resident hit him because he wore their clothes but the garment in question did belong to Resident #2. The responsible party stated the resident was institutionalized for over 3 years, initially at another type of facility, never hit or injured by another resident until this and as far as she knew, the resident had not caused any problems with any other residents. 2. Resident #1 had a MDS with a reference date of 8/3/17. The MDS indicated Resident #1 had an admission into the facility on 4/25/16 and had diagnoses that included non-Alzheimer's dementia. The MDS indicated the resident had a BIMS score of 15 and without symptoms of delirium. A History and Physical report, completed on 4/13/16 by a psychiatrist, indicated the resident had a history of dementia with aggressive behaviors. The resident kicked and was aggressive with residents and staff that day, and required treatment for the behaviors. The nursing Care Plan identified a potential for physical aggression and on 1/24/17 directed the staff to 1. Analyze times of day, places, circumstances, triggers and what de-escalates behavior (initiated 1/24/17). 2. Assess and anticipate resident's needs (initiated 1/24/17). 3. Modify environment: Adjust room temperature to comfortable level, reduce noise, dim lights, place familiar objects in room, keep door closed (initiated 1/24/17).	F 223		

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F 223	Continued From page 4 4. Monitor/document/report any signs or symptoms of resident posing danger to self and others (initiated 1/24/17). 5. Observe resident for any increase in verbal or physical aggression. Educate resident regarding non-use of physical aggression towards other residents (initiated 8/8/17). 6. When resident becomes agitated intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, if response is aggressive, staff to walk calmly away and approach later (initiated 1/25/17). 7. Psychiatric/psychogeriatric consult as indicated (initiated 1/24/17). The nurse's Progress Note entries identified the following: 1/25/17 at 11:30 a.m. - Resident #1 scratched another resident on the face that caused an abrasion, when the other resident took Resident #1's coffee. 1/27/17 at 3:57 p.m. - Yelled at other residents to "shut up", no physical behaviors. 2/13/17 - Resident asked if he wanted to move out of the low-stimulus unit to the general population and resident agreed "as long as he didn't have to share a room and could get away from crazy people". 8/8/17 at 5:30 p.m., transcribed by Staff F, registered nurse (RN) - resident approached another resident in lobby area at back nurse's station and accused him of wearing his shirt, hit that resident in the left eye. When resident asked why he hit the resident, the resident responded that he had his shirt on. A note transcribed on 8/24/17, by a psychotherapist, employed by a telemedicine	F 223		

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F 223	Continued From page 5 psychiatric service provider (services provided through live interaction via computer, similar to "skype"), described the resident had not had aggressive behaviors, with sad, flat, anxious and agitated affect. On 8/29/17 at 12:23 p.m., Staff M, social worker at a hospital, stated the resident was transferred to the inpatient geriatric psychiatric unit of the hospital from another facility in April, 2016, due to physical behaviors with other residents and that facility refused to allow the resident's return. On 8/31/17 at 2:20 p.m., Staff F stated the 8/8/17 incident was unwitnessed by staff, occurred by the television/lounge area at the back nurse's station during/after supper and not certain if other residents or which residents were in the area at the time, she was located at the front nurse's station at the time (approximately 100 feet away) and made aware of the event when Resident #2 walked to the front nurse's station with a bloody eye and said "He hit me, he hit me". Resident #2 was followed by Resident #1, who said "he has my shirt on", Resident #1 was anxious, paced by the kitchen door and remained in the area as she provided care for Resident #2. Staff F stated she was not aware that Resident #1 had any behaviors prior to that event. On 9/11/17 at 1:50 p.m., Staff E, CNA, stated he was only aware of 1 other incident with Resident #1 that occurred when the resident was still located in the dementia unit. Staff E stated another resident was behind him and tapped him on the shoulder. Resident #1 reacted, turned around and yelled, staff intervened, and thought the reaction was more due to the resident's surprise, but could tell the resident didn't like it.	F 223		

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F 223	Continued From page 6 On 9/13/17 at 1:20 p.m., Staff K, CNA, stated she worked on the night shift (10 p.m. to 6 a.m.). The resident wanted his door kept closed. The resident was incontinent at night, did not want staff in his room at night or incontinence care. Staff K stated unaware of any other behaviors the resident had with other residents at the facility as he stayed in his room at night. During an interview on 9/20/17 at 10:25 p.m., Staff L, CNA, stated the facility transferred the resident out of the dementia unit when they were tried to close the unit, the resident required some assistance if he/she toileted at night, and was not surprised that the resident struck another resident. During an interview on 9/6/17 at 4:40 p.m., the psychotherapist that provided the 8/24/17 visit stated she was not aware of any behavioral problems or the resident's 8/8/17 incident, and a contracted worker at the facility gathered information for their visit, had not informed her of the 8/8/17 incident. The psychotherapist stated she would have provided services and addressed the behavior if had known. During an interview on 9/7/17 at 11:09 a.m., the service coordinator contracted by the telemedicine psychiatric service provider stated Resident #1 was on her caseload since she began employment in April, 2017. The service coordinator stated the facility had not informed her of the 8/8/17 incident and the information would have been communicated with the psychotherapist for the 8/24/17 visit if known. She stated the resident was pleasant at times, but could also be angry and uncooperative, his	F 223		

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F 223	Continued From page 7 mood/affect was not predictable, and discharged from their services effective 9/5/17 due to non-compliance and frequent visit refusal. The facility policy and procedure titled Resident Abuse Policy and Procedure, dated 6/11/17, directed staff: 1. Each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion, mistreatment, neglect and misappropriation of personal property. 2. All facility staff members should be alert to the indicators of suspected or actual abuse and neglect. 3. The facility Administrator/designee is responsible for operationalizing all policies and procedures that prohibit abuse and neglect. 4. Abuse coordinators are the Administrator and Director of Nursing. They shall coordinate all investigations ensuring the patient's safety, and report findings to the regulatory agencies as required. 5. Physical abuse includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. 6. Employees will receive education related to abuse, neglect and misappropriation of resident property, involuntary seclusion and abandonment, and strategies for responding to aggressive and/or catastrophic reactions of residents. Residents must not be subject to abuse by anyone, including, but not limited to, facility staff, other residents, staff of other agencies serving the resident, or other individuals.	F 223		

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F 281	Continued From page 8	F 281		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff member interviews, the facility failed to implement and follow physician orders for 1 of 5 resident records reviewed (Resident #3). The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) Assessment tool dated 8/21/17 revealed Resident #3 admitted to the facility on 8/14/17 with diagnoses that included congestive heart failure, arthritis, edema and chronic pain. The MDS indicated the resident experienced intact cognition, displayed no symptoms of delirium and required extensive assistance of at least 2 staff for transfers to and from the bed and chair, bathing, toilet use and personal hygiene. The MDS contained no recorded height or weight and documented the resident as unable to stand or ambulate with a wheel chair as the primary mode of transportation. Physician orders dated 8/14/17 directed staff to weigh the resident daily in the morning and notify the physician with a weight gain of 2 pounds in 1	F 281		

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F 281	Continued From page 9 day. The nursing care plan included a potential for fluid volume overload related to congestive heart failure, initiated 8/23/17, and directed staff to monitor/document/report any signs or symptoms of fluid overload, edema, shortness of breath, difficulty breathing, increased respirations, difficulty breathing when lying flat, congestion, cough, fatigue, jugular venous distention, or sudden weight gain. An admission nutrition assessment note completed by the facility dietician on 8/15/17 revealed the resident experienced a recent 20 pound weight gain recorded in hospital notes and documented the resident's height and weight (447 pounds, height 60 inches) was gleaned from hospital records. The dietician also documented the facility's scale was broken. Record review on 8/29/17 revealed the order for daily weights transcribed on the August, 2017 Medication and Treatment Administration Records (MARS/TARS) failed to contain any documented weights, and no weight cold be found elsewhere in the resident's record. Observation on 8/28/17 at 1:35 p.m. revealed there wasn't a platform scale or other scale in the facility. Observation on 8/29/17 at 3:25 p.m. revealed a new platform scale in the therapy room, that staff used for the resident's weight, recorded as 355 pounds. Recorded weights reviewed on 9/7/17 revealed: 8/30/17 355.2 pounds	F 281		

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F 281	Continued From page 10 8/31/17 335.2 pounds 9/1/17 383.8 pounds 9/2/17 388.2 pounds 9/3/17 384 pounds 9/4/17 388.2 pounds 9/5/17 379.2 pounds 9/6/17 379.4 pounds 9/7/17 379.8 pounds Per record review on 9/7/17, the physician was not informed of the resident's weight changes. During an interview on 8/28/17 at 12:20 p.m., the resident stated he/she had not been weighed since admitted to the facility as staff said the scale was broken. During an interview on 8/29/17 at 2:10 p.m., the corporate administrator stated a new bariatric scale had arrived that day as the previous scale was broken during the annual survey completed 8/11/17; the facility had obtained another scale in the meantime which had also broken. During the same interview, the director of nursing stated the corporate office suggested the facility rent a scale, but the facility was unable to find one. During an interview on 8/30/17 at 10:20 a.m., the facility's corporate nurse confirmed the resident had a physician order for a daily weight and staff had not followed the order.	F 281		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free	F 323		

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F 323	Continued From page 11 from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident, family and staff interviews, the facility failed to ensure that each resident received adequate supervision to prevent accidents and injuries during a mechanical lift transfer (Resident #3). The sample consisted of 3 residents who required a mechanical lift transfer. The facility reported a census of 50 residents. Findings include: 1. Resident #3 had a Minimum Data Set (MDS) assessment with a reference date of 8/21/17. The MDS identified the resident had an admission into the facility on 8/14/17 and had diagnoses that included congestive heart failure,	F 323		

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F 323	Continued From page 12	F 323		

arthritis, edema and chronic pain. The MDS indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15. A score of 15 identified no cognitive impairment. The MDS identified the resident absent of symptoms of delirium, and required extensive assistance of at least 2 staff persons for transfers to and from bed and chair, bathing, toileting and personal hygiene. The MDS did not have a recorded height or weight and the resident could not stand or ambulate. The MDS identified the resident's primary mode of transportation as the wheel chair.

The Care Plan identified a problem on 8/15/17 with the resident's activity of daily living (ADL) deficit. The Care Plan interventions included and directed staff of the following:

Staff are to use a bariatric mechanical lift and bariatric mechanical lift sling when transferring the resident. This intervention was revised on 8/31/17.

Observation on 8/28/17 at 12:20 p.m. identified the resident seated in a recliner chair in her room, skin of lower legs intact, no sling under the resident, and 2 mechanical lift slings, both size "Large" located in the room. The slings were labeled by the manufacturer "User Weight Guideline For Proper Fit", with 175 to 249 pounds listed for the Large sling.

During an interview on 8/28/17 at 12:20 p.m., the resident stated the staff hurt her when they pushed on her legs during a mechanical lift transfers. The resident stated the staff do that in order to move her legs around the post of the lift when they used the smaller lift with blue padding

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F 323	Continued From page 13 on the hangers (Invacare 450 lift) or to position her farther over on the bed. The resident's first weight, obtained on 8/29/17, was 355 pounds. During an interview on 8/30/17 at 10:20 a.m. the facility's corporate nurse acknowledged the bariatric lift was required to transfer Resident #3 due to her height and stated staff should follow manufacturer's recommendations for mechanical lift sling selection based on the resident's size and weight. The corporate nurse stated all of the staff would be educated on lift sling selection specific to the resident and to use the bariatric lift for all Resident #3's transfers. The facility could not provide documentation that staff received training for the operation of a mechanical lift transfer. During an interview on 8/31/17 at 10:30 a.m., the corporate nurse stated all staff were educated on mechanical lift transfers, to transfer Resident #3 with the bariatric lift and appropriate sized sling. During an interview on 8/31/17 at 11:45 a.m., Resident #3 stated a CNA entered his/her room at 3 p.m. the day before and stated staff didn't have to use the bariatric lift, used the Invacare 450 lift to transfer the resident, the resident's feet hit the post of the lift during the transfer and it hurt. The Tollos size Large sling remained in the resident's room, the resident stated staff continued to use that sling even though it hurt her legs when they did. Observation on 9/6/17 at 10:45 a.m. revealed the resident seated in a recliner chair with her legs elevated. The resident had a large deep purple	F 323		

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	165453	A. BUILDING _____ B. WING _____	C 10/17/2017

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F 323	Continued From page 14	F 323		

bruise that nearly covered the anterior aspect of the right lower leg, with 2 fluid filled blisters present. The resident stated the injury occurred when Staff A, certified nursing assistant, grabbed her right lower leg when they transferred her to bed on 9/4/17. The resident stated as the staff tried to position the resident further over on the bed, Staff A must have pushed her leg too hard and it hurt. The resident stated she yelled out that it hurt and the staff said there was a bump on the leg. The resident stated the staff obtained a nurse (Staff C) and they transferred and weighed her in the therapy room. The resident stated she continued to have "awful" pain in the leg and Staff C informed her she had to go to the hospital emergency room.

Documentation recorded by Staff H, registered nurse (RN), on 9/6/17 at 2:11 p.m. revealed the right leg hematoma (collection of blood outside of the blood vessel) measured 22 centimeters (cm) by 24 cm, with a fluid filled blister that measured 11 cm by 0.5 cm.

A hospital ER physician report dated 9/4/17 indicated the resident received treated for a hematoma on the right leg. The physician ordered to apply an ice pack to the area for 15 minutes, 5 times per day for 2 days, with follow-up by physician.

A nurse practitioner (NP) from the hospital's physician's group, Staff I, assessed the resident on 9/6/17 and ordered an evaluation of the right lower leg that day at the hospital's wound clinic. The wound clinic visit note dated 9/6/17 revealed a blood filled blister, located on the right anterior lower leg. The NP "deroofed" (top layer over fluid removed) the blister and resulted in a 15 cm by

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F 323	Continued From page 15 15 cm by 0.5 cm partial thickness wound. The open area required application and treatment with a Mepilex AG dressing (soft absorbent dressing that contains silver nitrate, used as an antibacterial treatment). Observation on 9/7/17 at 11:55 a.m. identified the resident seated in a recliner chair with both legs elevated and a large gauze dressing covered the anterior portion of the right lower leg. The gauze dressing had approximately 2 inch by 4 inch area of serosanguinous drainage (yellow-pink colored body fluid) was visible on the lower margin of the dressing, towards the inner aspect of the leg, the skin visible below the dressing appeared reddened, and the right lower leg appeared larger than the left lower leg. The resident stated he/she had to return to the wound clinic that day for a dressing changed, and concerned about the potential for wound infection. Staff interviews related to the resident's right lower leg injury identified the following: On 9/6/17 at 11:31 a.m., the physician that treated the resident in the ER on 9/4/17 stated the resident told him the injury occurred when an aide grabbed it during a transfer with the lift. The physician stated he didn't have a specific opinion on how the injury had occurred, other than it resulted from force applied to the area and the area injured was larger than a hand but he did not rule that out as a potential cause of the injury. On 9/6/17 at 12:08 p.m., Staff I, NP, was interviewed after he assessed the resident and stated the resident voiced an aide grabbed her leg that caused the injury, but heard the 3 aides telling 3 different stories. Staff I stated something	F 323		

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F 323	Continued From page 16	F 323		

happened that caused the injury. Staff I stated the resident was well-known to him and the resident was always honest and he had no reason not to believe the resident.

On 9/6/17 at 12:02 p.m., Staff A, certified nursing assistant (CNA), stated she transferred the resident from the recliner to the bed on 9/4/17, with Staff B, CNA, and DON in room to ensure they used the right lift and sling, Staff B operated the controls and she held the loops of the sling as they moved the resident, turned the resident with her hands on the loops as they got her to the bed. Once the resident was in bed she complained of pain in the leg. Staff A stated she noticed a purple bump on the resident's leg, Staff B rubbed the area with lotion and they transferred the resident to the wheel chair for a weight check. Staff A stated after checking the weight, the resident said her leg really hurt and the bump had more than doubled in size by that time. Staff A stated Staff C sent the resident to the hospital emergency room.

On 9/6/17 at 8:19 p.m., Staff B, CNA, stated she transferred the resident after lunch with Staff A. Staff B stated Staff A lifted the resident's legs so she could pull the sling down and the resident complained of pain as Staff A lifted the legs. Staff B stated once transferred to bed, the resident said her leg hurt and the resident asked her to rub the leg. Staff B stated she applied lotion to the leg, noticed an egg-sized bluish-gray bump on the right lower leg. Staff B stated she stopped and went to get the nurse, Staff C. Staff C looked at the leg. Staff B stated she transferred the resident again, to obtain a weight, and the area was noticeably larger by then. Staff B stated it was within 10 minutes of when she rubbed the

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F 323	Continued From page 17 leg. On 9/6/17 at 1:59 p.m., the Director of Nursing (DON), was interviewed and stated she observed the CNA's, Staff A and Staff B, transfer the resident on 9/4/17 after lunch. The DON stated the sling under the sling appeared too high. Staff A lifted resident's legs under the knees as Staff B pulled sling down. Staff A's hands were positioned on the sling, resident's shoulders and thigh area, as Staff B operated the lift. The staff lowered the resident to the bed when Staff C entered the room and the DON left the room when Staff C entered. The resident had not complained of pain before that time. The DON stated she was later informed by Staff C that the resident had a large area on the leg and the area had gotten bigger when they weighed the resident. On 9/6/17 at 1:11 p.m., Staff C, LPN, stated she worked 6 a.m. to 6 p.m. on 9/4/17. Staff C stated the staff had gotten the resident up around 8 a.m., and then transferred the resident to use the bedpan around 10 or 11 a.m. Staff C stated she had verified the staff used the right sling and lift at those times. Around 1:30 p.m. or 1:45 p.m., she was going to lunch break and not aware staff wanted to transfer the resident. The staff got the DON to observe the transfer. While in the breakroom, someone informed her of the transfer, when she went to the room the DON was in the room with the staff, so she went back to the break room. While still in the break room, staff came and informed her resident complained of pain in his/her leg. She assessed the resident's leg and observed a 50 cent-sized vesicle (blister) without color on the leg. Staff C stated she remained in the room as staff	F 323		

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F 323	Continued From page 18 transferred the resident from the bed to the wheel chair and then to the therapy room for a weight. The resident complained of pain as they lifted her from the chair on the scale. Staff C stated she looked at the leg and the blister had more than doubled in size, still without color. The resident was sent to the emergency room. Staff C stated she assessed the area around 5:15 p.m. after return from the hospital. Staff C stated the area had no change of color or bruising and identified a rectangular shaped blister. On 9/6/17 at 3:22 p.m., Staff J, physical therapy assistant (PTA), stated he worked at the facility on 9/4/17 between 11:45 a.m. and 2:15 p.m. Staff J stated he provided therapy to the resident in her room before staff weighed the resident and did not observe anything abnormal on the resident's legs. Staff J stated he was in the therapy room when staff brought her in for a weight and he assisted with the transfer after he heard the resident say "owe". Staff J stated when he first saw the blister on the leg; it appeared as golf-ball sized as and more than twice the size when they left the therapy room. While in the therapy room he heard the resident say the aides hurt her leg, and the aides and nurse said "No, they did not". On 9/6/17 at 10:55 a.m., an incident report was requested and documents related to the resident's 9/4/17 injury. The Corporate Administrator stated the staff had not completed an incident report but would complete one and they would investigate the injury.	F 323		

Pearl Valley Rehab – Washington Facility ID # 165453

601 East Polk Street
Washington, IA 52353
Phone: 319-653-6526

Provider's Plan of Correction for Complaint Survey

Conducted July 11-13, August 28-31, September 6-7,

October 13, 2017

Response to CMS-2567

F 000: Initial Comments

This plan of correction constitutes our credible allegation of compliance with a date of October 26, 2017.

F 223 FREE FROM ABUSE/INVOLUNTARY SECLUSION

Survey findings were shared with all staff the week of October 24, 2017 by the administrator. All staff were educated regarding the concerns about abuse due to resident to resident altercations.

All residents are at risk for resident to resident altercations due to community living situation.

On October 26, 2017 training was conducted by the Administrator on resident to resident altercations. Policy and procedure were reviewed and updated as needed. Policy and procedure for abuse and reporting of suspected abuse were reviewed with staff during the in-services and all questions were answered.

All suspected abuse will be reported immediately to management staff. All residents involved in altercation will be assessed immediately by nursing staff. Each situation will be investigated and reported to Department of Inspection and Appeals for further evaluation. This process will be taken to QA monthly for the remainder of the year or more frequently if any issues are identified.

F281 Services Provided meet Professional Standards

Survey findings were shared with all staff the week of October 24, 2017 by the administrator. Education was started with nursing staff during the complaint investigation due to issue being identified. New scale was ordered on 8/25/2017 and delivered to facility on 8/29/2017 with a 800lb weight limit.

All residents are at risk due to dependence on staff for weight monitoring and processing of physician orders.

All orders will be audited by nurse management to ensure that all orders are being followed as written. Physician orders will be audited M-F for one week, twice a week for four weeks, monthly for two months, and then random audits as needed with all results reported to the QA committee for review.

F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

Survey findings were shared with all department the week of October 24, 2017 by the Administrator. All staff were educated regarding the concerns of improper hoyer transfer policy and procedure issues and individual skill audits given to nursing staff.

Residents at risk for accidents if facility transfer policy is not followed and residents are dependent on staff for transfers and mobility.

Transfer education and skill audits were started immediately. Audit completed on 10/26/2017 to verify completion of training. New bariatric lift and slings ordered for the facility to help ensure that appropriate slings are available at all times. Care plans were updated to reflect the sling size and kardex were placed in a secure location in each resident room to reflect the sling that is needed for transfer.

All suspected occurrences of inappropriate transfers will be reported to management immediately. Residents will be evaluated on admission and minimally quarterly after this to ensure that correct equipment is being used or with any possible change in resident condition. This issue will be taken to QA monthly for the remainder of the year or more frequently if any issues are identified.