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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165615	A. BUILDING _____ B. WING _____	C 12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER VALLEY LIVING AND REHAB	400 SERGEANT SQUARE DRIVE SERGEANT BLUFF, IA 51054

(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: 1/15/23 ✓ A recertification health survey and investigation of complaint #105182-C was completed 12/12/22 - 12/15/22 and resulted in the following deficiencies. JB Complaint #105182-C was Substantiated See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	See attached	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to refer a resident to the appropriate state-designated authority for a Level II Preadmission Screening and Resident	F 644		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
T. Nick	Administrator	12/30/2022

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 644	Continued From page 1 Review (PASARR) evaluation and determination status change who was identified with a newly evident mental disorder for one (Resident #12) of two residents reviewed. The facility reported a census of 48 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #12, dated 11/25/22, included diagnoses of Schizophrenia and Depression. The PASRR Level I Screen Outcome for the resident, dated 12/1/21, documented Major Depression only, with no documentation of a Schizophrenia diagnosis. The PASRR outcome documented the following: there is no evidence of a PASRR condition of a serious behavioral health condition and if changes occur or new information refutes these findings, a new screen must be submitted. On 12/13/22 at 12:59 PM, the Director of Nursing (DON) stated that after the resident was admitted, the facility learned that the resident had a diagnosis of schizophrenia. The DON stated she did not complete a status change PASRR for the diagnosis of schizophrenia and her expectation for a PASRR status change to be completed with a new diagnosis.	F 644		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		

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F 684	Continued From page 2	F 684		

that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record review the facility failed to provide timely assessments and interventions for 2 of 12 residents reviewed. Resident #8 had chronic kidney disease and was consulting with an urologist as his condition worsened. The facility failed to put a follow up appointment on the calendar and he missed this appointment. Resident #23 had chronic diabetic wounds and the facility failed to implement a treatment order to his feet. The facility reported a census of 48 residents.

Findings include:

1) According to the Minimum Data Set (MDS) dated 11/11/22 Resident #8 had a Brief Interview for Mental Status (BIMS) score of 6 (severe cognitive deficit). The resident required set up assistance and the help of one staff for bed mobility, transfers and toileting. The resident used a walker and a wheelchair for mobility.

A Care Plan updated on 12/7/22 showed that the resident had a urinary catheter placed due to urinary retention. Staff were directed to observe for signs and symptoms of infection. The resident was seeing a urologist for worsening kidney function. Resident #8 diagnoses included transient cerebral ischemic attack, muscle wasting, retention of urine, and chronic kidney disease.

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F 684	Continued From page 3	F 684		

A Nursing Note dated 12/13/22 at 11:15 AM showed that Resident #8 had blood in his urinary catheter with some clots noted. The resident was shaking, very weak, and had difficulty standing. The facility sent the resident to the emergency room.

On 12/14/22 at 7:15 AM Staff A, Certified Nursing Assistant (CNA), said that it was around 7 AM on 12/13/22 when she noticed a significant amount of blood in the resident's urine and she notified the nurse right away. Staff A said that she cared for the resident the previous day and noticed that his urine was dark. She said that she told the nurse on duty but did not know if there was any follow up at that time. She said that Staff C, Registered Nurse (RN), did assess the resident right away on 12/13/22 but another nurse commented that the color of the urine wasn't concerning because his urine always looked like that.

A review of the resident's record revealed a note from the urology office dated 10/24/22 that indicated the resident had a follow up appointment on 12/6/22 at 9:45 AM.

On 12/14/22 at 8:16 AM the receptionist at the urologist office said that Resident #8 had been seen by the doctor on Oct. 24th at 11:00 AM and they arranged for a follow up appointment for 12/6/22. The receptionist said that the resident did not show up for that appointment and they did not get a call from the facility to reschedule.

On 12/14/22 at 9:59 AM the Director of Nursing (DON) acknowledged that Resident #8 missed an appointment with the urologist on 12/6/22. She said that the nurse failed to put the appointment

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F 684	Continued From page 4	F 684		

on the schedule, therefore, it didn't get processed so he was a no show.

2) According to the MDS dated 10/21/22, Resident #23 had a BIMS score of 8 (moderate cognitive deficits). The resident required supervision only for transferring and walking. The resident required extensive assistance of one person for toilet use.

The Care Plan updated on 6/1/22 showed that Resident #23 had activities of daily living (ADL) self-performance deficits related to a history of cerebral infarction. The resident was admitted to the facility with skin concerns and had an amputation of the second toe on their left foot because of a chronic diabetic ulcer. He had diagnoses of neuropathy and type II diabetes. The staff were directed to monitor his feet regularly.

On order entered in the Electronic Medical Record (EMR) on 12/5/22 at 11:41 AM directed the staff to soak the resident's left foot in Epsom salt for 10-15 minutes daily, apply triple antibiotic ointment to the left greater toe, and cover with a band aid until it was healed.

According to a document titled: Weekly Skin Observation signed on 12/4/22 at 10:28 PM, Resident #23 had redness to his groin areas. His right great toe had a small scab to the area above the toenail and his left great toe was red and swollen. The right side of the nail bed appeared to have a small part of the nail missing and there was some serosanguineous drainage noted.

On 12/13/22 at 2:18 PM Staff C said that she did not know of an order for the resident's foot to be

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F 684	Continued From page 5 soaked daily. The Medication Administration Record and the Treatment Administration Record (MAR/TAR) lacked documentation that the staff soaked the resident's foot as ordered. On 12/13/22 at 2:32 PM, Staff C took off the sock from the resident's left foot and the great toe started to bleed. Staff C cleaned the toe and put a bandage on it. On 12/14/22 at 9:28 AM, the DON said that there had been an error in the entry of the foot soak order so it wasn't showing up on the MAR/TAR. The DON did not know if the foot care was getting completed.	F 684		
F 836 SS=E	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS	F 836		

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F 836	Continued From page 6	F 836		

regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph.
This REQUIREMENT is not met as evidenced by:
Based on clinical record reviews and staff interviews, the facility failed to submit 4 of 8 residents admissions reviewed to the Iowa Department of Veteran Affairs (Resident's #26, #2, #21, #39). The facility reported a census of 48 residents.

Findings include:

1. A review of the clinical record revealed Resident #26 admitted to the facility on 9/23/22.

Review of the resident's questionnaire for Veteran Affairs (VA) Benefit Eligibility revealed Resident #26 was a Veteran's Widow(er).

The Iowa Department of Veterans Affairs Resident Eligibility form with a print date of 12/12/22 revealed Resident #26 was not listed on the form.

2. A review of the clinical record revealed Resident #2 admitted to the facility on 8/18/22.

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F 836	Continued From page 7	F 836		

Review of the resident's questionnaire for VA Benefit Eligibility revealed Resident #2 was a Veteran's Widow(er).

The Iowa Department of Veterans Affairs Resident Eligibility form with a print date of 12/12/22 revealed Resident #2 was not listed on the form.

3. A review of the clinical record revealed Resident #21 admitted to the facility on 7/14/22.

Review of the resident's questionnaire for VA Benefit Eligibility revealed Resident #21 was a Veteran's Widow(er).

The Iowa Department of Veterans Affairs Resident Eligibility form with a print date of 12/12/22 revealed Resident #21 was not listed on the form.

4. A review of the clinical record revealed Resident #39 admitted to the facility on 10/27/21.

Review of the resident's questionnaire for VA Benefit Eligibility revealed Resident #39 was a Veteran's Widow(er).

The Iowa Department of Veterans Affairs Resident Eligibility form with a print date of 12/12/22 revealed Resident #39 was not listed on the form.

An Interview on 12/14/22 at 2:20 p.m., the Administrator verified Residents #26, #2, #21 and #39 were not submitted to the Iowa Department of Veteran Affairs within 30 days of admission. The Administrator reported Resident's #26, #2,

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F 836	Continued From page 8 #21, and #39 did get submitted to the Iowa Department of Veteran Affairs on 12/14/22.	F 836		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842		

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F 842	Continued From page 9	F 842		

law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record review the facility failed to accurately document completed wound care treatments for 1 of 3 residents reviewed (Resident #23). Staff C, Registered Nurse (RN), documented completion of treatments four hours earlier than the completion of the task. The facility reported a

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F 842	Continued From page 10	F 842		

census of 48 residents.

Findings include:

According to the MDS dated 10/21/22, Resident #23 had a BIMS score of 8 (moderate cognitive deficits). The resident required supervision only for transferring and walking. The resident required extensive assistance of one person for toilet use.

The Care Plan updated on 6/1/22 showed that Resident #23 had activities of daily living (ADL) self-performance deficits related to a history of cerebral infarction. The resident was admitted to the facility with skin concerns and had an amputation of the second toe on their left foot because of a chronic diabetic ulcer. He had diagnoses of neuropathy and type II diabetes. The staff were directed to monitor his feet regularly.

The Electronic Health Record (EHR) included that following orders:
a. An order dated 11/25/22 at 3:00 PM directed the staff to check the resident's feet for sores, red spots, and pressure areas along with an order to monitor the right great toe for signs of infection.
b. An order dated 6/10/22 at 3:00 PM to check feet daily for sores, red spots, and pressure areas from shoes.
c. An order dated 12/10/22 at 12:23 AM to apply nystatin powder to the groin three times a day.

According to the Medication Administration Record and the Treatment Administration Record (MAR/TAR) The groin treatment was completed on 12/13/22 at 9:56 AM and the feet had been checked at 12:52 PM.

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F 842	Continued From page 11 On 12/13/22 at 2:18 PM Staff C, Registered Nurse (RN), said that she hadn't done any treatments or looked at the resident's feet yet that day. On 12/13/22 at 2:32 PM Staff C took off the resident's sock from his left foot and the great toe started to bleed. She reported that she did not know the resident had an open area on the toe and put a bandage on the toe. She had the resident go into the bathroom and sit on the toilet while she cleaned some old powder from his groin and applied new. The resident said that the staff would provide this treatment from time to time but it was not done every day. On 12/14/22 at 7:18 AM the Director of Nursing (DON) stated that staff were expected to provide treatment before documenting that it had been completed. 12/15/22 at 8:50 AM the DON said that the facility did not have a specific policy for nursing documentation but staff were educated that the expectation was for staff to complete a task before it was documented as having been done.	F 842		

Pioneer Valley Living and Rehabilitation
400 Sergeant Square Drive
Sergeant Bluff, IA 51054
Provider #165615

F000

This is the Plan of Correction for the annual survey that was conducted on 12/12/22-12/15/22. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because provisions of federal and/or state law require it. This Plan of Correction as constitutes my credible allegation of compliance. The facility will be in compliance by January 15th, 2023 with all deficiencies.

F644

All residents, including #12, have updated PASARR on file.

All residents, including #12, will have PASARR done before entering building.

DON will attend continuing education classes of PASARR training. Along with updating PASARR as residents needs change.

Every admission/readmit/change in resident condition will be audited for 12 weeks by the Administrator/Designee to ensure compliance.

QA committee to review monthly as needed.

F684

All residents, including #8 and #23, have appointments audited to ensure all residents attend appointments as scheduled.

All residents, including #8 and #23, charts will be audited to ensure appointment reminders or cards are in appointment book.

All appointments cards, calls, reminders will go to DON/Designee.

Every appointment will be audited for 12 weeks by Administrator/Designee to ensure compliance.

QA committee to review monthly as needed.

F836

All residents, including residents #26, #2, #21, and #39, reviewed to the Iowa Department of Veteran's Affairs.

All residents, including residents #26, #2, #21, and #39, will have Veteran Affairs Benefit Eligibility entered.

Admissions coordinator educated on importance of Veteran Affair Eligibility entered on 12/15/2022.

Every admission will be audited for 12 weeks by the Administrator/Designee to ensure compliance.

QA committee to review monthly as needed.

F842

All residents, including resident #23, have treatments documented after completion.

All residents, including #23, have documentation times audited.

Documentation education provided on proper documentation protocol. All nurses educated by January 15, 2023.

Education and expectation, documentation of tasks will be audited for 12 weeks by DON/Designee to ensure compliance.

QA committee to review monthly as needed.