STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165585	A. BUILDING _____ B. WING _____	**04/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEARL VALLEY REHABILITATION AND HEALTHCARE CENTER	**2002 CEDAR STREET MUSCATINE, IA 52761**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, pharmacist and resident's responsible party interviews, the facility failed to administer medications as ordered and prescribed for 1 of 3 resident records reviewed (Resident #3). The facility reported a census of 73 residents. Findings include: The [DATE] Minimum Data Set (MDS) Assessment Tool revealed Resident #3 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Hospital Discharge and Transfer Physician order [REDACTED]. [MEDICATION NAME] (an anti-anxiety medication) 0.25 milligrams (mg) administered oral 3 times daily for 14 days. The last scheduled dose on [DATE] at 2:00 p.m. 2. [MEDICATION NAME] 0.25 mg administered oral as needed 1 time daily for 7 days. The last day staff could administer the medication was on [DATE]. 3. [MED] (an antipsychotic medication for the treatment of [REDACTED]. The March, 2020 Medication Administration Record (MAR) revealed the following: 1. All doses of the [MEDICATION NAME] scheduled 3 times daily, administered at 8:00 a.m., 2:00 p.m. and 9:00 p.m., were documented as administered. 2. The [MEDICATION NAME] ordered 1 time a day as needed was administered on [DATE], [DATE] and [DATE]. 3. The [MED] was not administered between [DATE] and [DATE], the date the resident expired at the facility. A Narcotic Inventory Control Sheet labeled [MEDICATION NAME] 0.25 mg 1 tablet 3 times a day for 14 days, 42 tablets dispensed on [DATE], revealed the medication not administered as scheduled and documented on the MAR at the following dates and times by staff: [DATE] 2:00 p.m. Staff A, Licensed Practical Nurse (LPN) [DATE] 9:00 p.m. Staff B, Registered Nurse (RN) [DATE] 9:00 p.m. Staff B [DATE] 2:00 p.m. Staff C, LPN The same Inventory Control Sheet revealed the medication administered after discontinued after the 2:00 p.m. dose on [DATE], by the following staff: [DATE] at 8:00 a.m. by Staff D, LPN [DATE] at 2:00 p.m. by Staff D [DATE] at 11:00 p.m. by Staff B The narcotic Inventory Control Sheet labeled [MEDICATION NAME] 0.25 mg 1 tablet daily as needed for 7 days, 7 tablets dispensed on [DATE], revealed the medication administered after [DATE] when the order expired: [DATE] at 10:00 p.m. Staff B [DATE] at 12:00 a.m. Staff B [DATE] at 1:00 a.m. Staff E, RN Narrative Nurse's Notes and the MAR did not reveal documentation why [MEDICATION NAME] administered on [DATE], [DATE] or [DATE], or the effectiveness of the medication administration. Staff interviews revealed the following: a. On [DATE] at 3:56 p.m., Staff E, RN, stated on the night of [DATE] and early morning of [DATE], the resident was anxious, she medicated him and was helpful. b. On [DATE] at 10:34 a.m., Staff F, facility Registered Pharmacist, stated there were no orders to continue the [MEDICATION NAME] medication beyond the original order, and the order for [MED] required pre-authorization that was initially approved on [DATE], then declined by the facility on [DATE]. The Pharmacist stated [MED] should not be discontinued abruptly, from 10 to 20 days after a missed dose the person would have increased anxiety and agitation that would increase the longer it lapsed, with behaviors that included hallucinations and outbursts. The Pharmacist stated there were alternatives for replacement of the medication, and the facility should have sought orders from the physician for that. c. On [DATE] at 1:06 p.m., Staff G, RN and Nursing Director at the group home where the resident resided before facility admission stated the resident received the [MED] as ordered on [DATE]. d. On [DATE] at 8:07 a.m., the facility Director of Nursing (DON) stated nurses should document the reason when medications are administered as needed, and also record the effectiveness of the medication, nurses should administer medications as ordered by physician or contact the physician for clarification when indicated, and confirmed the resident had not received [MED] at the facility (the medication was due on [DATE]). During an interview on [DATE] at 10:15 a.m., the resident's Guardian and responsible party stated the resident took [MEDICATION NAME] 3 times a day and as needed for many years, and had also received the [MED] injections for at least 3 or 4 years, and required the medication for treatment of [REDACTED].

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