STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165387	A. BUILDING _____ B. WING _____	**06/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEARL VALLEY REHABILITATION AND NURSING AT PRIMGHA	**735 NORTH RERICK PRIMGHAR, IA 51245**

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to develop and implement speech therapy strategies in the comprehensive care plan for 1 of 5 residents reviewed (Resident #5). The facility reported a census of 32 residents. Findings include: According to the Minimum Data Set (MDS) assessment, dated 5/29/20, Resident #5 scored 12 on the Brief Interview for Mental Status (BIMS) indicating some cognitive impairment. The resident required set up and 1 person physical assist with eating. The resident's [DIAGNOSES REDACTED]. A hospital form dated 5/13/20 documented the resident admitted after an unresponsive episode with acute [MEDICAL CONDITION] (brain disease, damage, or malfunction), [MEDICAL CONDITION] activity, dysphagia, and history of [MEDICAL CONDITION]. The resident's hospital course complicated by aspiration pneumonia. An Inpatient Speech Therapy Plan of Care dated 5/19/20 documented the resident had cognitive impairments and needed 1 to 1 supervision for safety. The functional level at discharge with eating included supervision/set up. A Speech Therapy Evaluation and Plan of Treatment dated 5/26/20 documented swallowing abilities required close supervision. Speech Therapy services for dysphagia were warranted to minimize aspiration/risks of in order to enhance the resident's quality of life by improving ability to safely consume the highest level of oral intake. The recommended level of skilled therapy services required due to difficulties with alternating and divided attention. Recommended close supervision for oral intake with alternation of liquids/solids and rate modification. Resident instructed in use of compensatory strategies to address swallow dysfunction focusing on alternating bites/sips, resident response to low stimulation environment when eating, presentation techniques to increase safety and nutrition and small bites/sips (1/2 to 1/3 teaspoon). Skilled interventions to address problem solving skills included exercises to increase selective attention to task with resident success 30% attempts and with 50% verbal cues. A Speech Therapy Progress Report and Updated Therapy Plan documented 6/9/20, the resident stand by assist with 20% verbal cues with eating. An undated therapy form directed the resident to have supervision with meals due to aspiration risk and decreased attention. The Care Plan dated 6/10/20, lacked identification of the resident's dysphagia or recommendations of speech therapy. The Nurse's Notes dated 6/12/20 documented the nurse called to the dining room due to the resident choking on a piece of food. During an interview on 6/22/20 at 11:40 a.m., Staff D, Certified Nurse Aide (CNA) stated the resident had no problem eating and fed himself. She said assisted residents ate in the dining room. During an interview on 6/22/20 at 12:50 a.m. Staff E, CNA stated the resident fed himself, and ate better around people. The resident ate regular diet with no issues with choking. She did not know if he received speech therapy. During an interview on 6/22/20 at 3:42 p.m. Staff B, CNA stated she sat in the room when the resident choked. She said the resident usually fed himself, and had no special diet. She said a CNA had to be in the dining room at all times. She never knew the resident to have difficulty with eating. On subsequent interview 6/24/20 at 8:07 a.m. Staff B stated the resident ate in the dining room due to his fall risk. During an interview on 6/22/20 at 1:10 p.m. the Speech Therapist stated the resident had been on the caseload. There were concerns with his lack of attention during meals. The resident had a regular texture, thin liquid diet, and they sometimes needed to cut things up or cue him. She never discontinued (having someone) sit with the resident. He needed to take small bites. She thought he took his pills in pudding. She said the resident would forget what he was doing. On subsequent interview on 6/24/20 at 7:45 a.m. the Speech Therapist stated supervision with eating included 1 to 1 in the line of sight watching the resident eat, usually a CNA or a nurse. She said the resident needed low stimulus environment and to be attentive to eating. During an interview on 6/22/20 at 1:48 p.m. Staff A, Activity Assistant stated she sat at the table with the resident (6/12/20) when he choked on chicken. During subsequent interview on 6/24/20 at 9:06 a.m. Staff A stated she did not supervise the resident eating (6/12/20). She did not know he needed a low stimulus environment when he ate or of his need to be attentive to eating. During an interview on 6/23/20 at 11:09 a.m., the Dietary Supervisor stated the resident ate in the dining room because he would stand up and had an identified fall risk. During an interview on 6/24/20 at 7:51 p.m. Staff C, Social Services stated she thought the resident probably ate in the dining room because he needed supervised. She said they always had an aide in the dining room. During an interview on 6/24/20 at 9:40 a.m. the Speech Therapist stated the Administrator pointed out that she did not put resident's need for low stimulation on her recommendation, and she would need to spell things out better, The facility Meal Supervision Policy included the facility would provide supervision of residents identified to have swallowing or increased choke risks for all meals and snacks by certified/licensed staffing.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** Based on record review and staff interview, the facility failed to assure records contained a complete and accurate record of resident assessments for 1 of 5 residents reviewed (Resident #4). The facility reported a census of 32 residents. Findings include: According to the Nurse's Notes dated 6/8/20 on the 2-10 p.m. shift Resident #4 arrived at the facility at 4 p.m. from another nursing facility. The resident demonstrated confusion and inability to use the call light. The resident banged on the wall to call for help. On admission the resident's temperatures ranged from 99.8-100.9 degrees. After offering a cool cloth the resident's temperature registered 98.9 degrees. The resident complained of shortness of breath while lying flat, and the head of the bed elevated to 30 degrees and oxygen (O2) administered at 3 liters with an oxygen saturation (sat) of 93%. The resident had a catheter on admission and the facility the resident transferred from called and stated it could be removed anytime, he had it placed for the transport. Upon removal of the catheter blood clots were noted at the tubing of the catheter. When they pulled the catheter the resident had a lot of blood mixed with clots. The resident complained of abdominal pain. Staff notified the physician regarding the concern. The physician stated nothing they could do, okay for the blood clots to come out instead of staying in the resident. The blood decreased after 1 hour of cleaning. The Nurse's Notes lacked the time the resident beat on the wall, staff removed the resident's catheter, started the O2, or called the physician, According to the Nurse's Notes dated 6/9/20 on the 10 p.m. to 6 a.m. shift the resident rested quietly, vital signs within normal limits. They noted a small amount of blood in the resident's incontinent pad with cares. The notes lacked a record of the vital signs, when they were taken or the last time staff visualized the resident. The Nurse's Notes dated 6/9/20 at 7:25 a.m. documented staff found the resident without pulse or respirations. During an interview on 6/22/20 at 2:16 p.m. Staff F, Licensed Practical Nurse (LPN) stated she took the resident's catheter out at the end of the shift. She said when he went to bed he complained of shortness of breath so she checked is O2 sat and it registered 88% (not documented), so she started O2 per the facility protocol. She did not think he had O2 on when he

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

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

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) arrived at the facility. She thought his lung sounds were okay (not documented). During an interview on 6/22/20 at 2:34 p.m. Staff H, CNA stated the 2-10 shift reported the resident being rambunctious and rude. She said he slept during the night shift. She did not have to do anything with him, she just checked to make sure he was in bed. She last saw the resident around 4:30 p.m. She didn't wake him up but his hand moved so she figured all okay. During an interview on 6/22/20 at 2:47 p.m. Staff I, CNA stated the resident hollered a lot, kicked, fought, punched the wall, and acted out of control. During an interview on 6/22/20 at 3:36 p.m. Staff J, CNA stated when they took the resident's catheter out he had a little blood. She said he had more after that around 8 or 9 o'clock. She said they put O2 on the resident when he laid in bed. He said he needed it because he couldn't breathe. He screamed he needed his pills, so the nurse gave him his pills, and he continued to scream. She said it took a long time to get him cleaned up. During an interview on 6/23/20 at 8:12 a.m. Staff G, Registered Nurse (RN) stated she recalled the resident and said he slept pretty well through the night. She checked on him several times. She said his temperature ranged from 98.7 to 98.9 and O2 sat 92-93%. She could not say what O2 administered at but thought 2-3 liters. She said he woke up during the night but really did not say much. She said not much bleeding from post catheter removal and he had no complaints of abdominal pain. He did not exhibit behaviors and she probably last saw him at 5 to 5:30 a.m. and he slept. She said her assessment should be an a skilled nursing form. During an interview on 6/23/20 at 10:54 a.m. the Director of Nursing (DON) stated the resident admitted intermediate level of care so he did not have a skilled nursing form, so there was no other documentation. At 3:50 p.m. the DON stated the resident assessments should be documented in the residents record.