STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	**08/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	**506 EAST FOURTH STREET SUTHERLAND, IA 51058**

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 REDACTED]. 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. 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) 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, 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. 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 what caused the incident, but thought maybe the room was too crowded. She said the resident

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 0689 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) 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 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 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], Resident #3 admitted to the facility on [DATE] 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 [DIAGNOSES REDACTED]. 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 [DATE]. 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. 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. 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 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 [REDACTED]. 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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** 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 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

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) task such as working with ready to eat foods and discarded when damaged, soiled or when an interruption occurred in the operation.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] at 7:50 a.m. Staff H, Housekeeping took surveyors 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 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 [DIAGNOSES REDACTED]. 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 [MEDICAL CONDITION] with a history of UTI's seen for follow up of UTI on [MEDICATION NAME] (antibiotic), reports increased drainage from suprapubic catheter site. A culture taken from the catheter site exudate 6/26/20 resulted in treatment for [REDACTED]. 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 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	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 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.