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 _____	08/05/2021

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

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F 000	INITIAL COMMENTS Correction date_____ A recertification health survey and investigation of Complaints #94348 and #96985 was completed 8/2-5/21 and resulted in the following deficiencies. Complaint #94348-C, Substantiated Complaint #96985-C, Not Substantiated (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C)	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	F 578		

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

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F 578	Continued From page 1	F 578		

and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to ensure the physician signed a resident's code status paperwork for 2 out of 12 residents reviewed (Resident #12 and #82). The facility reported a census of 32 residents.

Findings include:

1. The Minimum Data Set (MDS) dated 4/25/21 for Resident # 12 documented diagnoses of type 2 diabetes (chronic condition that affects the way the body processes blood sugar), chronic obstructive pulmonary disease (COPD)(group of lung diseases that block airflow and make it difficult to breathe), and hypertension (high blood pressure) The MDS showed the Brief Interview for Mental Status (BIMS) score of 8 (moderate cognitive impairment).

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Review of Resident #12's Iowa Physician Orders for Scope of Treatment (I-Post) dated 5/5/2021, revealed Resident #12's Do Not Resuscitate (DNR) status not signed by the physician and lacked a date with the signature of the staff member that prepared the IPOST form.

Review of Medication Review report signed 7/15/21 by the physician revealed and order for "DNR; see IPOST with an order date of 5/5/21".

The care plan revised 6/17/21 revealed the resident's Advance Directive as a DNR hospice care and medical interventions revealed "see IPOST".

On 08/03/21 at 03:20 p.m., the Director of Nursing (DON) brought a copy of the IPOST signed by the physician dated 8/3/21. The DON stated that the IPOST should have been signed prior to 8/3/21.

Iowa Department of Public Health website titled, IPOST Form and Guidance, Description of the IPOST form visited 8/3/21 and copyrighted 2021, revealed according to the statute, the IPOST form shall be a uniform form and shall have all of the following characteristics: Patient's name and date of birth, signed and dated by the patient or patient's legal representative, signed and dated by the patient's physician, advanced registered nurse practitioner, or physician assistant and signed and dated by the facilitator if the preparation of the form was done by an individual other than the patient's physician, advanced registered nurse practitioner, or physician assistant.

2. The admission record for Resident #82 revealed an admission date of 7/27/21 and listed

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F 578	Continued From page 3 diagnoses of malignant neoplasm of unspecified site of female breast, sepsis and neutropenia. The resident's Care Plan dated 7/27/21 revealed Advanced Directives would be honored by facility staff and directed staff to send a copy of the IPOST for all level of care change transfers. The Care Plan further revealed the resident had a terminal illness. Review of the resident's IPOST on 8/3/21 at 9:41 AM revealed it did not contain a physician signature. On 8/5/21 at 7:55AM, Staff D, Licensed Practical Nurse (LPN) revealed she would initiate cardiopulmonary resuscitation (CPR) if she observed an IPOST not signed by the resident's physician. Staff D, LPN further revealed without the Physician's signature the IPOST is not official. On 08/4/21 at 3:20 PM, the Quality Assurance nurse brought a copy of the resident's IPOST signed by the hysician dated 8/4/21.	F 578		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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 observations, staff interviews and record review the facility failed to meet professional standards by not removing expired medical supplies from stock to prevent unsafe	F 658		

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F 658	Continued From page 4 medication administration due to possible product deterioration. Findings: a. A count of 24 Swab Caps expired on 4/30/21. b. A count of 5 Insyte Needles 22 gauge expired on 4/30/21. c. A count of 2 Insyte Needles 24 gauge expired on 4/30/21. d. A count of 1 Insyte Needle 20 gauge expired on 6/3/19. On 08/03/21 at 02:48 PM, Staff F, Licenced Practical Nurse (LPN), acknowledged the supplies outdated. Staff F stated the Quality Assurance Nurse (QA Nurse) tracked expiration dates and typically removed the expired items from the medication room. On 8/04/21 at 3:30 PM, Director of Nursing (DON), stated the facility did not have a policy related to surveillance of medical supply dates. The DON acknowledged the QA Nurse should have removed the expired needles and caps. On 08/04/21 at 03:24 PM, QA Nurse acknowledged he should have removed the expired needles and caps from the medication room before they expired. The document titled Quality Improvement: Consultant Pharmacist Summary by Omicare dated 5/10/21 instructed staff to verify routine medication storage audits are completed to review for dating, labeling and ensuring outdated items are removed.	F 658		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		

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F 812	Continued From page 5 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record and policy review, the facility failed to store food in a manner that prevented foodborne illness and to keep food in accordance with professional standards for food service safety. Facility census was thrity-two (32) residents. Findings include: An initial kitchen tour conducted on 08/02/2020 at 10:45 AM revealed the following observations: a. Five jars of Grey Poupon with an expiration date of 7/12/2021. b. Five containers of Crisco with an expiration date of 5/2020. c. A tray of pear crisp dessert found in the	F 812		

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F 812	Continued From page 6 refrigerator to be uncovered and unlabeled. d. A hairnet worn by Staff C observed to leave unrestrained hair exposed midway up the back of the head. On 08/02/2020 at 10:45 AM, the Dietary Manager (DM), stated the expired canned food should not be in the storage area and planned to discard the items after the kitchen tour. The facility does not have a process for tracking expiration dates. The DM verbalized the dessert should be covered and labeled, she instructed the staff to complete the task immediately. The document titled Food Receiving and Storage (undated) instructed all foods stored in the refrigerator or freezer will be covered, labeled and dated. The document also revealed dietary staff shall wear hair restraints so that hair does not contaminate food. The document titled Competencies for Food and Nutrition Services Employees (undated), located within the Facility Assessment, instructed employees to use hair restraints and beard guards properly. The document also indicated that staff should wrap, date and label foods properly.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		

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F 880	Continued From page 7 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 8	F 880		

disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interview, and record review, the facility failed to implement proper infection control standards when providing care for 1 of 12 residents observed (Resident #3) and failed to follow proper hand hygiene protocol during 1 observation of medication administration. The facility reported a census of 32 residents.

Findings include:

1. The Minimum Data Set (MDS) dated 4/25/21 for Resident #3 documented diagnoses of hypertension (high blood pressure), Basal Cell Carcinoma (type of skin cancer that begins in the basal cells), and Osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down). The MDS showed the Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment.

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Observation on 08/02/21 at 01:40 p.m., revealed Staff A, certified nursing assistant (CNA) and Staff B, CNA entered Resident #3's room to assist the resident to bed. Staff A, CNA did not wash hands and applied gloves, Staff B, CNA performed hand hygiene and applied gloves. Staff A, CNA and Staff B, CNA wore gloves and swung the foot pedal around the wheelchair, then hooked up the hoyer lift sheet with gloves on. Staff A, CNA ran the control lifting Resident #3 into bed. Staff B assisted Resident #3 into bed and took off the resident's shoes and raised the bed with the same gloves on. Staff A, CNA and Staff B, CNA, without changing gloves, took Resident #3's pants down and and opened a clean brief, then opened the soiled brief, and then took wipes out of the package. Wearing the same gloves, Staff B CNA told Resident #3 what she planned to do and completed perineal care. Staff A, CNA rolled Resident #3 toward Staff B, CNA and rolled up the soiled brief and reached over Resident #3 and handed it to Staff A, CNA to throw into the trash can. Staff A, CNA did not change gloves and took clean brief and put it under Resident #3 and assisted resident to roll towards Staff B, CNA. Staff A, CNA with the same gloves pulled the clean brief under Resident #3 and pulled up and fastened the clean brief with the same gloves. Staff A, CNA with the same gloves checked Resident #3's ostomy bag. With the same gloves Staff A, CNA removed the ostomy bag and cleansed the stoma with the same gloves and a clean wipe. Once the stoma was cleansed, Staff A CNA wearing the same gloves applied a new ostomy bag and secured the bag in place. Staff A CNA wearing the same gloves entered the bathroom to get an ostomy clip and opened the drawer with the supplies and

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could not locate the clip. Staff A CNA removed gloves and opened the door and left without performing hand hygiene. Staff B CNA wearing the same gloves, folded the bottom of the ostomy bag and covered Resident #3 with a sheet and a blanket. Staff B CNA wearing the same gloves then picked up the wipes package and placed the package into the bathroom, then stood next to the bed and put her hands (while wearing the same gloves) onto the side rail of Resident #3's bed. Staff B, CNA adjusted Resident #3's call light and walked back into the bathroom and with the same gloves on, opened the drawer with the ostomy supplies and found a clip. Staff B, CNA walked back over to Resident #3 ' s bed and folded the end of the ostomy bag and put the clip on to hold the bag closed. Staff A, CNA entered the room, no hand hygiene performed and assisted Resident #3 into a side laying position and placed a pillow to help with positioning. Staff B, CNA with the same gloves on, used the bed controls to lower the bed into the low position. Staff A CNA and Staff B CNA took the garbage out of the trash cans and tied them closed. Staff A CNA pushed the hoyer lift out into the hallway and did not perform hand hygiene before leaving Resident #3's room and Staff B CNA removed her gloves and performed hand hygiene.

Review of the facility policy titled Handwashing/ Hand Hygiene (undated) revealed general instructions for washing hands included before and after resident contact (i.e., meds, treatments, cares)

On 08/04/21 at 01:47 p.m., the Director of Nursing (DON) stated CNAs should change gloves when going from dirty to clean and should wash hands between glove changes and after

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F 880	Continued From page 11 entering a residents room and before leaving a residents room. The DON also stated staff should not perform ostomy care with dirty gloves. On 08/05/21 at 9:05 a.m., the Resident Care Coordinator stated the facility did not have a glove usage policy. 2. On 08/02/21 at 02:12 PM, Staff C, Certified Medical Assistant (CMA), failed to perform hand hygiene after a sublingual medication administration via syringe for Resident #10. Staff C exited the room, placed the syringe in a glass of water located on the medication cart then wiped both hands up and down her scrub shirt. Staff Ccontaminated other areas as she returned the medication to the inside of the cart and documented the medication administration. On 08/04/21 at 3:25 PM, the Administrator and the Director of Nursing both agreed staff did not follow proper hand hygiene practices.	F 880		