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
	165355	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEOTA HEALTH CARE CENTER	204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248

(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 3/9/17 The following deficiencies relate to the facility's annual health survey. (See code of federal regulations (42CFR) Part 483, Subpart B-C)	F 000	**Plan and/or execution of this plan or correction does not constitute admission or agreement by this provider of the truth of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and/or State Law.**	
F 156 SS=B	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.	F 156	**F156 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES** **The facility does ensure compliance with Medicare regulations for skilled service residents by giving the option to request an appeal of the decision to end Medicare coverage of therapy prior to being discharged from skilled services.** **For the required Plan of Correction, the facility submits the following:**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Matthew Simcox, LNHA — TITLE: Administrator — (X6) DATE: 3/1/17

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.

CS 3/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEOTA HEALTH CARE CENTER	204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248

(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 156	Continued From page 1 (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]	F 156	• Residents are given the option to request an appeal of the decision to end Medicare. The decision to discharge residents from skilled services is discussed with the Interdisciplinary Team at the weekly Medicare meeting and the notices are generated using the CMS denial letters guide. • Recent notices were reviewed and verified by the MDS Coordinator. • The Director of Nursing and MDS Coordinator were educated on when to use the ABN and Generic Notices on 2/10/17. • The Director of Nursing and MDS Coordinator will attend the weekly billing triple check meeting to ensure notice compliance and results will be reviewed with the QA committee. • The Director of Nursing and MDS Coordinator will be responsible to ensure that the proper Right to Appeal notice is to given to all residents discharging from skilled. • Completion date 3/9/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEOTA HEALTH CARE CENTER	204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248

(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 156	Continued From page 2 (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEOTA HEALTH CARE CENTER	204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248

(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 156	Continued From page 3 program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEOTA HEALTH CARE CENTER	204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248

(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 156	Continued From page 4 amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEOTA HEALTH CARE CENTER	204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248

(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 156	Continued From page 5 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure compliance with Medicare regulations for 2 of 3 skilled service residents (Resident # 1 & #6) by failing to give the option to request an appeal of the decision to end Medicare coverage of therapy prior to being discharged from skilled services. The facility census was 20 residents. Findings include: 1. Clinical record review revealed Resident #6 changed from skilled care to an intermediate level	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEOTA HEALTH CARE CENTER	204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248

(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 156	Continued From page 6 of care on 11/23/2016. The facility failed to provide the Notice of the Right to Appeal that would give the resident a choice to request an appeal to continue with therapy or decline further service. 2. Clinical record review revealed Resident #1 changed from a skilled level to the intermediate level of services on 12/30/16. The facility failed to provide the Notice of the Right to Appeal the termination of therapy or request an appeal. During interview on 2/7/17 at 1:50 P.M., the Administrator confirmed neither resident received the Right to An Appeal form.	F 156		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, facility policy review and staff interview, the facility failed to ensure two of five residents observed received services as planned. (Resident #5 & #3). The facility census was 20 residents. Findings: 1. The Minimum Data Set (MDS) assessment dated 11/3/16, documented Resident #5 had diagnoses that included Parkinson's disease, anxiety and depression and required extensive assistance for bed mobility and personal hygiene.	F 312	**F312 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS** **A resident who is unable to carry out activities of daily living does receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene.** **For the required Plan of Correction, the facility submits the following:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEOTA HEALTH CARE CENTER	204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248

(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 312	Continued From page 7 During observation on 2/7/17 at 11:15 a.m., Staff C, Certified Nurse Aide, CNA cleansed the resident's inguinal folds, frontal perineal area and inner thighs in a front to back direction while the resident laid in bed. The resident laid on a disposable pad saturated with urine. Staff C and Staff D, CNA rolled the resident onto the left side and Staff C cleansed the resident's inner right buttock and rectum in a front to back direction with a disposable wipe. Staff D did not cleanse the resident's right outer buttock or right hip. Staff C and Staff D rolled the resident onto the right side and Staff D removed the soiled pad. Staff C cleansed the back of the resident's left thigh, left inner buttock, and rectum in a front to back direction. Staff C did not cleanse the resident's left outer buttock or left hip. After the completion of the personal cares, Staff C and D transferred the resident to a sitting position in a wheelchair using a mechanical lift. To boost the resident up in the chair, the staff members lifted the resident by holding on to the the legs and under the resident's arms. The care plan dated 6/12/13, stated the resident was at risk for impaired skin integrity related to incontinence and directed staff to provide incontinence care following each episode. The facility undated Perineal Care policy stated the purpose of perineal care was to refresh the resident, cleanse the perineum, and prevent infection and odor and directed staff to cleanse all areas in contact with urine. During interview on 2/8/17 at 2:30 p.m., the Director of Nursing stated staff should cleanse all parts of the body in contact with urine.	F 312	• Resident #5 does receive complete perineal care. Staff C and D were re-educated on 2/7/17 on the importance of complete perineal care. The CNA care sheets were updated for residents that receive perineal care to include that care needs to be complete by cleansing all affected areas. • The facility reviewed the current policies for perineal care in department stand-up and during staff huddles. • Nursing staff were in-serviced on 2/8/17 on infection control precautions, perineal care, catheter care and two person transfers. On 3/1/17 the CNAs and Nurses were in-serviced by the Director of Nursing on proper perineal care techniques. The CNAs then demonstrated the proper procedures back to the Director of Nursing. Nurses and CNA staff were given a copy of the policy for perineal care. The policy was also placed in the nursing communication book. The CNA staff were each assigned the Health Care Academy on-line Activities of Daily Living course.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEOTA HEALTH CARE CENTER	204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248

(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 312	Continued From page 8 2. The MDS assessment date of 12/27/16, revealed Resident #3 required the assistance with ambulation and transfers and had history of one fall while at the facility. The plan of care with an initiation date of 1/9/17 directed staff to transfer the resident with one assistance and a gait belt, assist to the toilet before and after meals, upon rising in the morning, at the hour of sleep and as needed. Staff should provide safety at all times. During observation on 2/6/17 at 2:00 p.m., Staff A, CNA and Staff B, CNA assisted the resident back to her/his room. Staff A placed a gait belt around the resident's waist and Staff B held the resident's left hand and placed their other hand on the gait belt. Staff A held the resident under the right arm axilla and grasped the top of the resident's slacks to pull her/him to a standing position. The resident stood stooped forward and to the right side and ambulated haltingly into to the bathroom. Once finished with the toilet, Staff A and Staff B lifted the resident into a standing position with Staff B grasping the resident under the arm as before. Staff B continued to hold the resident under the right arm axilla while assisting to stand and return to the wheel chair. The resident continued to use a halting gait, stooped forward and leaning to the right. During interview on 2/8/17 at 1:20 p.m., the Director of Nursing verbalized Staff A might have used the top of the slacks and under the resident's arm due to a lose gait belt, but went on to say holding/lifting under the arm axilla was never a good idea.	F 312	• Random perineal care audits will be completed by the Director of Nursing and MDS Coordinator weekly for four weeks then monthly for two months then annually. The results of the audits will the reviewed with the QA committee. • The Director of Nursing and MDS Coordinator will be responsible to ensure ADL cares including perineal care is completed properly. •Resident #3 and #5 does receive safe transfers with proper gait belt use. Staff A, B, C, and D were re-educated on safe transfers using a gait belt in place of lifting a resident under the arms. Additional gait belts for staff to utilize were ordered. • The facility reviewed the current policies for two person transfers in department stand-up and during staff huddles. • Nursing staff were in-serviced on 2/8/17 on infection control precautions, perineal care, catheter care and two person transfers.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEOTA HEALTH CARE CENTER	204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248

(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 312	Continued From page 9 The undated facility policy for a Two Person Transfer directed staff to lift gently, putting pressure on the gait belt only.	F 312	On 3/1/17 the CNAs and Nurses were in-serviced by the Director of Nursing on two person transfers using a gait belt and repositioning in place of lifting under the arms. The CNAs then demonstrated the proper procedures back to the Director of Nursing. Nurses and CNA staff were given a copy of policy for safe transfers. The policies were also placed in the nursing communication book. The CNA staff were assigned the Health Care Academy on-line Activities of Daily Living course. • Random transfer audits will be completed by the Director of Nursing and MDS Coordinator weekly for four weeks then monthly for two months then annually. The results of the audits will the reviewed with the QA committee. • The Director of Nursing and MDS Coordinator will be responsible to ensure ADL cares including transfers are completed properly. • Completion date 3/9/17.	
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide ROM(range of motion) exercises in order to prevent a decline for 1 of 3 residents reviewed with a ROM program(Resident #5). The facility reported a census of 20 residents. Findings include: 1. Resident #5 had a MDS (Minimum Data Set) assessment with a reference date of 5/24/16. The assessment identified the resident had diagnosis including Parkinson's disease, anxiety and depression. The MDS indicated the resident required extensive assistance of 1 staff person for eating, extensive assistance of 2 staff for bed mobility and personal hygiene and depended totally on 1 staff for bathing. The resident	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEOTA HEALTH CARE CENTER	204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248

(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 318	Continued From page 10 depended totally on 2 staff for transfers and dressing. The MDS identified the resident had no impairments in ROM in the upper or lower extremities. The MDS assessment, dated 11/3/16, indicated the resident required extensive assistance of 1 staff for bed mobility and personal hygiene, depended totally on 1 staff for eating, and depended totally on 2 staff for transfers, dressing, toilet use, and bathing. The MDS indicated the resident did not walk during the MDS review period and the resident had impairments in ROM on both sides of the upper and lower extremities. The MDS listed the resident's cognitive skills as moderately impaired. During an observation on 2/8/17 at 11:00 a.m., Staff D CNA(Certified Nursing Assistant), Restorative Aide completed ROM exercises to the resident's upper and lower extremities. The resident had a left wrist contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) and left foot drop. The resident did not have full range of motion in the left fingers and had a rolled up washcloth in the left hand. The resident's Restorative Care Plan, dated 9/8/16, directed staff to complete 10 repetitions of the following exercises three times per week: a. hip and knee flexion and extension b. hip abduction c. ankle dorsal and plantar flexion d. shoulder flexion e. elbow flexion and extension f. wrist flexion and extension The facility lacked a Restorative Care Plan prior to 9/8/16.	F 318	**F318 483.25(c)(2)(3)** **INCREASE/PREVENT DECREASE IN RANGE OF MOTION** **A resident with limited range of motion does receive appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. A resident with limited mobility does receive appropriate services, equipment and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.** **For the required Plan of Correction, the facility submits the following:** • Resident #5 does receive a restorative program to maintain mobility as prescribed. • The facility added a Restorative Nurse on 2/20/17 to oversee the restorative program and she will review daily documentation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEOTA HEALTH CARE CENTER	204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248

(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 318	Continued From page 11 Review of facility documentation revealed the resident participated in Physical Therapy from 8/26/16-9/9/16 and Occupation Therapy from 8/26/16-9/8/16. ROM documentation for the resident for the survey year from 3/3/16 through 2/6/17 revealed staff completed ROM exercises the following days and durations: 1/24/17 25 minutes 1/26/17 no minutes listed 1/27/17 no minutes listed 1/30/17 25 minutes 1/31/17 no minutes listed 2/2/17 25 minutes 2/3/17 no minutes listed 2/6/17 25 minutes 2/7/17 25 minutes The facility lacked documentation of additional ROM exercises completed in the survey year. Care plan entries, dated 6/9/14, stated the resident usually required extensive assistance of 2 staff for bed mobility and utilized a Hoyer(mechanical)lift and 2 staff members for transfers. A care plan entry, dated 1/17/17 identified the resident required passive ROM exercises to the upper and lower extremities 5 days per week. The facility policy and procedures titled Range of Motion (ROM) Splints, Braces, Orthotices, dated 8/2009, directed the staff that residents at risk for contractures had a ROM program a minimum of 6 days per week unless contraindicated in order to maintain the resident's ability to move a joint	F 318	The Restorative Nurse has assessed all residents to ensure that they are receiving appropriate restorative programs as prescribed and the programs are documented according to professional standards. All restorative documentation is now completed in electronic format and the daily documentation is reviewed by the Restorative Nurse. • The Restorative Aide and Restorative Nurse are now attending the weekly Medicare meetings to review discharged residents, residents with any decline in ADLs, significant changes and therapy screens for restorative programs. • The Restorative Aide was re-educated on the importance of restorative to prevent any decreases in mobility or range of motion. The Restorative Aide was also re-educated on the importance of documenting after each program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEOTA HEALTH CARE CENTER	204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248

(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 318	Continued From page 12 through its normal range of movement and perform activities of daily living. During an interview on 2/8/17 at 11:24 a.m., Staff D stated she started completing ROM exercises at the facility in November 2016 after returning from helping out at a sister facility. She stated in her absence, she doubted the CNAs had time to complete the ROM exercises with just 2 CNAs on the floor. During an interview on 2/8/17 at 1:31 p.m., Staff C CNA stated the CNAs left ROM up to the Restorative Aide and stated it was "tough" to complete ROM exercises with only 2 CNAs on the floor. During an interview on 2/8/17 at 2:30 p.m., the DON(Director of Nursing) stated she could not locate additional ROM documentation for the survey year.	F 318	The Restorative Aide was assigned a Health Care Academy online course on Restorative and ROM and also received the IMG manual on Restorative Nursing. Nursing staff were also educated on completion of restorative tasks and documentation. • The Restorative Nurse and Director of Nursing will complete monthly audits on the restorative nursing notes and will evaluate the program to ensure that is effective and appropriate. Results will be reviewed with the QA Committee. • The Director of Nursing and Restorative Nurse will be responsible to ensure that the restorative programs are completed and documented. • Completion date 2/23/17.	