STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165396	A. BUILDING _____ B. WING _____	C 04/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER HILLS VILLAGE IN KEOKUK	20 VILLAGE CIRCLE KEOKUK, IA 52632

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F 000	INITIAL COMMENTS Correction Date 4/24/18 Complaint 74540-C and facility reported incident 74851-I were investigated and substantiated on 3/27/18 - 4/10/18. See Code of Federal Regulations, 42 CFR, Subpart B-C.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, and resident, responsible party, staff and physician interviews, the facility failed to ensure residents received care and treatment in accordance with professional standards based on a comprehensive assessment for 1 of 5 residents reviewed (Resident #5). On 2/14/18, Resident #5 began having nausea, vomiting and loose stools. The facility failed to notify the physician of the resident's complaints of nausea and her continued vomiting and loose stools. On 2/19/18, the resident's Responsible Party took her to the physician's office. The physician directed the family to take the resident to the hospital to be treated for dehydration, and she was admitted to	F 684	F684 SS=G On 03/28/2018, Nursing Staff was in-serviced on our Resident Condition Policy and expectations of attending physician notification of resident changes. Nursing staff was also in-serviced on utilizing the comprehensive assessment for identifying risks for changes in resident status and the process for monitoring/timely notifications of those changes once they occur to ensure proper care and treatment in accordance with professional standards. (continued on next page)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heather M Ballew	Administrator	5-18-18

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	Continued From page 1 the hospital that day. The facility reported a census of 49 residents. Findings include: The Minimum Data Set (MDS) Assessment tool dated 2/19/18 revealed Resident #5 admitted to the facility on 2/7/18 with diagnoses that included dementia with behavioral disturbance, congestive heart failure and repeated falls. The MDS documented the resident scored 4 out of 15 possible points on the Brief Interview for Mental Status (BIMS) cognitive assessment (severe cognitive impairment), had symptoms of delirium present, and required extensive assistance of staff for transfers to and from bed, ambulation (walking), bathing, dressing and toilet use. The MDS revealed the resident remained continent of bowel with occasional urinary incontinence, weighed 89 pounds and was identified as an unplanned significant weight loss of 5 percent or more. The nursing care plan documented the resident as at risk for dehydration on 2/8/18, with a 5/8/18 goal for the resident to have adequate hydration. The care plan directed staff to encourage fluids, monitor for symptoms of dehydration (dry mouth, dry skin, fatigue, weakness, poor skin turgor), and monitor labs. Nurse's Notes contained the following entries: 2/7/18 at 1:22 p.m. by Staff J, licensed practical nurse (LPN), admitted to facility, weight 103.2 pounds. 2/7/18 at 11:54 a.m. by Staff K, LPN, open area to gluteal cleft, 2 centimeters (cm) by 0.5 cm, with redness to surrounding skin, area tender to	F 684	The Director of Nursing and/or assigned delegate will monitor resident change in conditions by use of event reporting and progress note reviews daily to ensure compliance with monitoring/notifications. Upon regular review of reports and documentation, compliance was achieved 4/24/2018. The Director of Nursing and/or assigned delegate will continue to monitor events and progress notes randomly ongoing to ensure continued compliance.	

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F 684	Continued From page 2 touch. 2/8/18 at 2:02 p.m. by Staff J, request sent to physician for Arginaid (a protein supplement drink), vitamin C and Zinc orders related to current skin conditions. 2/9/18 at 4:15 p.m. the facility's registered and licensed dietician stated the resident ate 76 to 100 percent of meals, and estimated her caloric requirements between 1410 and 1535 calories, with 38 to 47 Grams of protein, and 1175 milliliters of water per day, noted request for Arginaid, Vitamin C and Zinc related to multiple areas of impaired skin integrity. 2/14/18 at 9:02 a.m. by Staff J, physician faxed (document transmitted by facsimile) for resident's request for scheduled laxative, with order for 1 Senna S 8.6-50 milligram tablet administered oral daily (a laxative) received. 2/14/18 at 10:26 p.m. by Staff K, resident not hungry for supper, started to have some loose stools and moderate amount of vomiting of undigested food while at the table. The resident was very tired and requested to go to bed. Abdomen slightly firm with some distention noted. Had 2 more smaller emesis and loose stools with some formed stool, continue to monitor status. 2/15/18 at 12:28 p.m. by Staff J, increased complaints of nausea, clear soda encouraged. 2/15/18 at 11:15 p.m. by Staff K, the resident had a couple of loose stools with 1 formed stool, no emesis, ate chicken noodle soup for supper. 2/16/18 at 11:58 p.m. by Staff R, LPN, multiple loose stools, afebrile, no complaints of nausea. Faxed MD (on a Friday evening) with request for Loperamide order (anti-diarrhea medication), awaiting a response. 2/17/18 at 1:11 p.m. by Staff N, LPN, 1 loose stool, refused to get up for breakfast, clear liquids given, poorly taken, drank around 200 milliliters,	F 684		

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F 684	Continued From page 3 vomited a small amount of liquid which appeared to be the Arginaid. 2/18/18 at 5:18 a.m. by Staff M, LPN, 1 loose stool, no emesis. 2/18/18 at 8:17 p.m., by Staff L, LPN, 1 loose stool, never wants to eat when put at table has small emesis and then gets to go to her room, once in her bed she is fine, wants to go home. 2/19/18 at 1:05 p.m. by Staff J, out of facility with family. 2/19/18 at 11:10 p.m. by Staff S, LPN, contacted resident's responsible party (RP) due to the resident had not returned to the facility, RP stated they took her to the doctor and she was admitted to the hospital. Records of bowel movements (BM) revealed the resident had: 4 large, 1 medium and 1 small BM on 2/14/18 2 large and 2 small BM on 2/15/18 1 large BM on 2/16/18 5 large BMs on 2/17/18 3 large BMs on 2/18/18 1 medium and 1 large BM on 2/19/18 A weight of 101 pounds was recorded at 6:10 a.m. on 2/10/18. A weight of 89 pounds was recorded at 11:17 a.m. on 2/18/18. The Medication Administration Record (MAR) revealed the resident received the Senna-S laxative medication oral daily from 2/15/18 through 2/19/18. The Change in a Resident's Condition policy, dated 12/03, directed staff: 1. The resident or resident's representative and	F 684		

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F 684	Continued From page 4 attending physician shall be promptly notified of changes in the resident's condition or status. 2. The nurse will notify the physician when there is a significant change in the resident's physical, mental, or psychosocial status, or if there is a need to alter the resident's treatment significantly, or if deemed necessary or appropriate in the best interest of the resident. 3. Except in medical emergencies, notification will be made within 24 hours of a change occurring in the resident's condition or status. Staff interviews revealed: 4/2/18 at 4:25 p.m., Staff H, certified nursing assistant (CNA), stated the resident didn't eat well, said she didn't feel good and didn't want to eat, staff encouraged her to eat. Staff H reported she offered super cereal (high calorie cereal) and resident refused it. 4/2/18 at 4:31 p.m., Staff I, CNA, stated the resident didn't want to eat and vomited 1 or 2 times after a couple of bites of food at the table. Staff I gave the resident lemon-lime soda, which seemed like-it helped, but she would throw that up as well, because she threw everything up. 4/2/18 at 4:35 p.m., Staff J, LPN, stated the resident complained of nausea but denied it when asked, and didn't act as ill as what her family said. During another interview on 4/3/18 at 8:36 a.m., Staff J stated they gave Arginaid daily for skin/wound problems, but the resident said she thought it made her stomach upset and she had loose stools. The resident didn't eat or drink a lot. 4/3/18 at 9:08 a.m., Staff K, LPN, stated the resident's appetite was poor, didn't want anything	F 684		

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F 684	Continued From page 5 to eat, and had nausea and vomiting for a couple of days. Staff K thought the doctor was faxed about the resident's her nausea. Staff stated they offered clear liquids and soups; the resident had liquid stools but also had formed stools, and reported her abdomen was slightly firm with sluggish bowel sounds. 4/3/18 at 9:37 a.m., Staff L, LPN, stated the resident had issues with eating, but would eat ice cream. Staff L commented she was not sure if it was the food or because she wanted her family to take her home. 4/3/18 at 5:40 a.m., Staff M, registered nurse (RN), stated the resident had loose stools, she didn't administer medication to the resident on the night shift, and thought it was passed in report the resident threw up so she could go back to her room. Staff M stated if a resident complained of nausea and threw up she would check their vital signs and would call the doctor if needed, she wouldn't fax that information. 4/3/18 at 9:15 a.m., Staff F, CNA, stated the resident got sick after she ate and threw up, she saw this twice, the resident threw up at the table and the nurse knew that. The resident said she was constipated, but when she went to the toilet she expelled clear liquid mucous with a small amount of light brown stool, and the nurse knew that as well. 4/3/18 at 9:51 a.m., Staff G, CNA, stated the resident didn't eat much and she threw up in the dining room after she drank a certain drink (Arginaid), but was able to eat if she didn't drink it. Staff G stated the nurse knew the resident threw up after the drink.	F 684		

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F 684	Continued From page 6 4/3/18 at 11:05 a.m., upon request for any documentation that the residents conditions were reported as appropriate to the physician, the director of nursing (DON) provided a copy of the 2/16/18 fax with request for Loperamide. The DON stated she expected staff to timely notify the physician, resident, family or RP of resident condition changed or requests for treatment changes for changes in resident conditions. 4/3/18 at 8:44 a.m., the nurse at the resident's physician office, stated after thorough search at the office she was not able to find any other communication from the facility about the resident's nausea, vomiting, loose stools or weight loss. The nurse reported the resident was seen in the office on 2/19/18, she was very weak and the doctor told her family to take her to the Emergency Room because she was dehydrated. An office visit note dated 2/19/18 documented the resident was evaluated for acute dehydration and abdominal pain, and presented with 4 days of vomiting, very weak, tired, and barely able to hold her head up. The note revealed the resident hypotensive (low blood pressure), acutely ill, and the physician suspected a partial intestinal obstruction or ileus (partial bowel paralysis). The physician had also documented the resident had experienced intractable vomiting with nausea and acute and profound dehydration. Office staff gave Phenergan (an anti-nausea medication) 50 milligrams via injection in the office, and the resident went to the Emergency Room for further assessment and administration of intravenous fluids. A hospital history and physical dated 2/19/18	F 684		

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F 684	Continued From page 7 revealed the resident admitted to the hospital after an ambulance transfer from another hospital, dehydration from 5 day history of nausea, vomiting and diarrhea, loss of appetite with 9 pound weight loss, and a BUN 104 mg/dl (blood urea nitrogen, a test of kidney function with normal range 7 to 20 milligrams per deciliter) and Creatinine of 3.1 mg/dl (another indication of kidney function with normal results from 0.5 to 1.1 mg/dl. Both results were critical lab values-when tested in July 2017, the resident's BUN was 38 and Creatinine 1.7). The abdominal X-ray revealed multiple dilated loops of bowel, a large inguinal hernia that contained bowel and was suggestive of a bowel obstruction. A hospital Discharge Summary dated 2/23/18 revealed the resident had been hospitalized for acute renal failure, and acute and chronic congestive heart failure secondary to gastroenteritis with dehydration. During an interview on 4/10/18 at 9:37 a.m., the resident's hospital physician stated the resident had a viral gastritis/gastroenteritis with 5 to 6 day history prior to hospitalization, was very dehydrated, and required intravenous (IV) fluid administration. The physician added that the IV fluid worsened the resident's congestive heart failure, required additional interventions, and lengthened her hospital stay. During an interview on 3/27/18, the resident's Responsible Party (RP) stated the resident had thrown up in the facility dining room for at least 3 to 4 days and she couldn't keep food down. The RP reported the staff didn't inform the doctor the resident wasn't eating and had gotten weaker, so he/she drove the resident to the doctor's office for	F 684		

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F 684	Continued From page 8 assessment. The doctor said the resident had severe dehydration, and told them to take her to the hospital. The RP drove the resident to the closest hospital, but that hospital didn't have an available bed due to flu; hospital staff put the resident in an ambulance for her transport to another hospital.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide adequate nursing supervision and assistance devices to prevent accidents for 1 of 2 residents reviewed (Resident #1). On 3/26/18, Resident #1 fell from a lift sling when two Certified Nursing Assistants failed to follow manufacturer mechanical lift directives regarding sling placement during a transfer. The resident sustained a closed fracture of the right femur (thigh bone). The facility reported a census of 49 residents. Findings include: The Minimum Data Set (MDS) Assessment tool dated 3/6/18 revealed Resident #1 had diagnoses that included diabetes, Alzheimer's disease, an above the knee amputation of 1 leg and	F 689	F689 SS=G On 3/26/2018, management clinicians began mandatory in-servicing of nursing staff on proper usage of the mechanical lift, correct sling option per resident statistics and proper sling placement for a safe transfer. Additional emphasis was placed during training on transfers from the chair back to the bed after residents were positioned in chairs over a period of time and identifying potential accident hazards prior to performing lifts. (continued on next page)	

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F 689	Continued From page 9 osteoarthritis. The MDS revealed the resident displayed severe cognitive impairment without symptoms of delirium, and required extensive assistance by at least 2 staff for transfers to and from bed and chair, dressing, bathing, toilet use and personal hygiene. The nursing care documented the resident as at risk for falls problem related to lower leg amputation and disorientation from Alzheimer's disease process, initiated 4/16/11. The care plan directed staff the resident required a full mechanical lift transfer by 2 staff, initiated 4/16/11 and documented an all staff in-service on full mechanical lifts, initiated 3/27/18. A history and physical report dated 3/29/18 revealed the resident admitted to the hospital on 3/26/18 with a closed fracture of the right femur (thigh bone) related to a fall from a mechanical lift at the nursing home. The report revealed the resident was at high risk for surgical intervention related to age and the resident's other disease processes. An orthopedic progress note dated 3/27/18 described the surgery as "canceled" and revealed the resident admitted to hospice services. The facility's self-reported incident, submitted 3/26/18, documented Resident #1 slid out of the front of the lift sling, landed on her buttocks on the floor. This occurred when staff transferred the resident from a Broda chair (wheel chair that reclines) with a mechanical lift by 2 certified nursing assistants (CNAs), and identified the resident's pants made of a slick material and the resident's movement while in the sling during the transfer as possible factors that contributed to the	F 689	Nursing staff also were required to perform return demonstrations of mechanical lift transfers to management staff to ensure compliance with safe resident handling. Upon completion of return demonstrations, compliance was achieved on 4/2/2018. The Director of Nursing and/or assigned delegate will continue to monitor resident transfers with nursing staff weekly for four weeks and randomly ongoing to ensure continued compliance.	

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F 689	Continued From page 10 fall. The administrator's written description of the fall investigation revealed the resident was transferred with a mechanical lift by 2 CNA's, Staff A and Staff B. The investigation revealed the Administer interviewed Staff B. Staff B guided the resident in the sling during the transfer, kept 1 hand on the sling as she used the other hand to move the Broda chair, the resident made an abrupt move during that time and the resident slid forward out of the sling to the floor. Staff A reported the resident wore new pants made from a slick material; Staff A operated the lift controls as Staff B held the sling, she elevated the resident high enough above the chair to clear it, Staff B held the sling and attempted to push the Broda chair out of the way. When Staff A backed the mechanical lift a bit to make room for Staff B to get to the front, the resident moved in the sling during that time, slid out of the front of the sling while elevated above the chair and landed on her bottom on the floor. The sling used was correct for the resident's weight and transfer method, all loops attached to the lift during the transfer, and the lower edge of the sling positioned at the resident's mid-thigh. Both CNA's reported a couple inches of the end of the resident's amputated leg hung over the lower edge of the sling. Staff performed a reenactment of the transfer with the lower edge of the sling positioned at the knee, mid-thigh, and higher than mid-thigh and found when positioned higher than mid-thigh there was enough flex with weight distribution to force weight forward and allow a slide, especially if pants were slick. A written statement by Staff A, dated 3/26/18, stated she operated the lift controls, Staff B held	F 689		

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F 689	Continued From page 11	F 689		

the sling and as she moved the lift back so Staff B could move the Broda chair, the resident jerked or stiffened and shifted herself. Staff A wrote as Staff B moved the chair, the resident slid bottom first out of the sling and hit floor. Staff A documented the sling had been positioned at mid-thigh, and the resident's pants were new and slicker than normal.

A written statement by Staff B, dated 3/26/18, stated she had her hand on the sling with the resident lifted enough above the Broda chair to clear it, and used her other hand to move the chair away. Staff B documented as Staff A pulled the lift away from the chair, the resident suddenly moved in the sling and went out the front of the sling, and landed with her rear end on the floor. Staff B wrote the sling was positioned at mid-thigh and her amputee was maybe 2 inches out from the sling.

Facility documents revealed a Tollos Ultralift, model TUL 3510XH and labeled as "#2" by the facility, used during the 3/26/18 incident. Product information sheets by Tollos described:

1. The "long seat six strap sling" designed for general purpose as well as single and double leg amputees (staff also called it a "full body sling").
2. The bottom edge of the long seat six strap sling should be located directly behind the knees.

Staff interviews revealed:

3/28/18 at 10:16 a.m., Staff A stated the long seat sling should be placed at the knees, the sling positioned at mid-thigh during Resident #1's transfer on 3/26/18, the resident had slid down in the chair after they got her up that day. During

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(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 689	Continued From page 12 another interview on 4/3/18 at 10:42 a.m., Staff A stated the sling was positioned at the mid-thigh and looked low enough, the 2 CNA's could have tried to work the sling down under her but thought it was down far enough. Staff A stated she now knew the sling had to be positioned at the knees. 3/28/18 at 11:13 a.m., Staff B stated when she transferred the resident back to bed with Staff A (on 3/26/18), the bottom of the sling was at the mid-thigh area, and the resident's amputated leg hung over the sling about 1 to 2 inches. Staff B reported she felt the resident's shoulder or back move when in the sling as she held the sling with 1 hand and moved the Broda chair with the other hand; Staff B was not sure which direction the resident went when she moved, and the resident had involuntary movements of her back. Staff B stated she knew before she watched the video the bottom of the sling was supposed to be at the knee level. 3/28/18 at 10:20 a.m., Staff C, CNA, stated the bottom of the full body sling is placed at the resident's knees. 3/28/18 at 11:39 a.m., Staff D, CNA, stated the top of the full body sling is placed above the shoulders, and the bottom would be at the knee. 3/28/18 at 11:36 a.m., Staff E, CNA, stated the middle loops of the full body sling is placed at the hip area, the bottom of the sling was usually at the knee area. 3/28/18 at 8:06 a.m., the administrator stated all CNA's watched a training video on use of the Tollos lift that included transfer with the long seat sling (also called full body sling) when on	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166396	A. BUILDING _____ B. WING _____	C 04/03/2018

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F 689	Continued From page 13 orientation, the facility periodically performed skills update education with all staff, and competency of CNA staff assessed annually that included a review of the Tollos video. After the incident, the facility was in the process of mandatory education with all CNA's and nurses that included the Tollos training video and staff required to perform a return demonstration of a mechanical lift transfer with the director of nursing (DON), assistant director of nursing (ADON) or the human resource manager (also a CNA). 3/28/18 at 10:04 a.m., the administrator stated Resident #1 sat a little reclined in the Broda chair, so she could have slid down a little on the sling which would have brought the bottom of the sling closer to the buttocks. 4/3/18 at 11:05 a.m., the DON stated she would have expected staff to reposition the lift sling to the correct position beneath the resident prior to transfer with mechanical lift.	F 689		