STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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	F 000		
Ok/CP	Correction Date 3/24/2023			
	The following deficiencies resulted from the Recertification Survey and investigation of Complaints #107832-C and #107930-C conducted on February 20, 2023 to February 23, 2023. Complaint #107930-C was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.			
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Hanson	Administrator	3/24/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to ensure that two (Resident (R) 21 and R25) of 27 sampled residents were treated in a respectful and dignified manner. Specifically, the facility allowed R21's body to be repeatedly exposed to public view due to ill-fitting pants and/or incontinence briefs. Multiple incidents in which the resident's pants fell down resluted in psychosocial harm, with the resident expressing embarrassment, becoming tearful, and/or expressing fear that she would be sent from the facility in response to the incident. Additionally, staff stood over the R25 while assisting the resident with eating, rather than sitting at the resident's eye level, maintaining face-to-face contact. Findings include:	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 550	Continued From page 2	F 550		

Review of an undated "Admission Agreement" indicated, "The resident has a right to be treated with respect and dignity."

1. Review of R21's undated "Resident Face Sheet," located in the resident's electronic medical record (EMR) under the "Resident" tab revealed the resident was admitted to the facility on 03/30/17 with a diagnosis of overactive bladder.

Review of R21's quarterly "Minimum Data Set (MDS)," located in the resident's EMR under the "RAI (Resident Assessment Instrument)" tab with an Assessment Reference Date (ARD) of 11/03/22, revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, indicating R21 was cognitively intact. This "MDS" also revealed R21 required limited assistance with toileting and was occasionally incontinent.

During an observation on 02/22/23 at 9:55 AM, R21 was observed, by two surveyors, ambulating independently with a walker down the hallway. R21 stopped and spoke with the surveyors and stated she was going to her counseling appointment. R21 was observed by both surveyors to wear pants that were approximately two sizes too large for the resident, and which were hanging nearly over her shoes.

During an observation on 02/22/23 at 10:13 AM, R21 was observed, by two surveyors, standing outside the facility, preparing to get into the van to leave for her appointment. At the time of this observation, the Activity Supervisor (AS) was observed adjusting R21's pants and appearing to tuck the waist band of the pants inward. This

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 550	Continued From page 3	F 550		

process lasted for about three minutes.

During an observation on 02/22/23 at 12:15 PM, R21 was observed walking down a hallway near the nurses' station. At the time of the observation, R21's pants and incontinence brief were observed to fall down around her ankles, exposing her bare bottom. Staff and other residents were present in the area. In response, R21 was then assisted by staff. At the time of this observation, R21 was wearing different pants from the previous two observations.

During an interview on 02/23/23 at 10:05 AM, R21 stated, "My briefs fall down about two times a day. I don't know why it happens; I guess because I urinate a lot and they won't stay up. Sometimes hard for me to put them on. They fell two times yesterday while I was at my counseling appointment. It is embarrassing and I don't know what to do. I got some safety pins but those might pop open and scratch me. Do you think that tape will work?" R21 further stated, "Yesterday when I went to my appointment, it was raining, and my pants and briefs fell right down, and my pants fell right into the puddle and got wet." R21 stated the AS, "was nice and she came back here and got me some dry pants and brought them back to the appointment with me. She even helped me put them on." R21 stated, "People see my backside all the time and it is embarrassing to be like that in front of people. They told me that they were going to tell the head of nursing for me."

During an interview on 02/23/23 at 11:27 AM, the Director of Nursing (DON) stated R21's incontinence brief falling down has been an ongoing issue for the past month. The DON further stated, "With the brief coming down, that's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 550	Continued From page 4	F 550		

embarrassing, and she has said that it is embarrassing. She should not have that happening to her. I can't spend her money for her but I have talked to the Social Services Director (SSD) three times about this issue and buying her some pants. I just talked to her this morning because of the pants and briefs falling down at the appointment yesterday. Today she is wearing a dress but it will still happen. I was thinking about biker shorts or something tight, so the heavy brief won't pull the pants down. The aides have tried tucking her pants into the top of her brief."

During an interview on 02/23/23 at 11:44 AM, Certified Medication Aide (CMA) 2 stated R21's brief falls about two to three times a day. CMA2 stated, "You are able to see her bare bottom, and this has been happening roughly for the last couple of months. When she soils her brief, it gets heavy and falls." When asked the measures the facility had put into place, CMA2 stated "I know we have tried briefs and pull-ups but it keeps happening. She wets so much that they fall. We have tried to put underwear over her briefs, but they still fall. She gets really embarrassed and will say that she is embarrassed. I talked to the nurses about it. Everybody knows that it happens. I guess they are trying to come up with a plan." CMA2 further stated that R21 has been more incontinent lately. CMA2 stated R21 is "independent in putting on her brief and we have told her to call for help when she is in the bathroom so that we can make sure that it is pulled up all the way up but I don't know how often she actually calls for help."

During an interview on 02/23/23 at 3:26 PM, the SSD stated, R21 "has been having stress incontinence and behaviors related to it." The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 550	Continued From page 5	F 550		

SSD stated, "She needs help with putting on her incontinence briefs and they are the kind with the sticky part and I don't think that she is able to get it on tight enough. I keep educating her on how to get it on. We have tried the pull-up kind and she stated those are uncomfortable to her. I think because of the way she is shaped like an apple; we can't get ones to fit her correctly. When she urinates, they fall because she doesn't have them pulled up far enough. Before her incident on yesterday that I was told about, the only other time that I know it happened was a little while back because it happened in my office. She had just left therapy and was coming to my office crying because she had an incontinent episode in therapy and her brief and pants fell down in my office. I made a note about it. This occurred on 12/30/22. The incontinence has been ongoing prior to December. When she had the incident yesterday at the doctor's office, the DON brought it to my attention, and we are going to have to figure something out. I was unaware of it happening before yesterday except for the time that it happened in my office. I was unaware that her bare bottom showed at any time."

Review of R21's "Resident Progress Notes," dated 12/30/22, written by the SSD, located in the resident's EMR under the "Resident" tab revealed the following: "Res [resident] expressing emotional reaction-Fearful/upset/crying Res came to SS [social services] office in tears and started to become more upset-crying harder. SS encouraged resident to take some big breaths and assisted her to sit-closed doors for privacy. Res was also malodorous. SS notes that Resident attends unit is around her ankles-wet-Resident reported that had an accident in the Therapy room--Res reported that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 550	Continued From page 6	F 550		

she doesn't want to "be taken away". Res expressed that she is fearful that she is going to be placed to another facility due to her accidents-with urine and occasional BM [bowel movement] incontinence. SS provided support and reassurance that she is not being discharged-nor sent anywhere else-as this is her home-till she asks for a referral otherwise. Res started to calm down and appeared to believe that she was "safe." Res stated that she doesn't understand why she is having so many accidents. SS talked with resident about going to the restroom more often-changing the type of brief that she is using--Res stated that it is hard to her to put on the other type of briefs and as she continues to use the "pull ups." SS reported that we would assist her with attaching the attends unit. Res also shared that she has been missing her son and Nephew and ... [son] had reported that he would come down to visit and has not--SS Notes that this had been an ongoing struggle with resident and her family not having strong contact. SS provided assists to resident's room-getting clean clothing-and linens. Resident much calmer-reported that she feels better-Res then walked to lunch. SS to continue to be available-as encouraged to Res."

During an interview on 02/23/23 at 3:40 PM, the AS stated, "I took her [R21] to her appointment yesterday. When we were getting ready to get on the van, her brief had fallen down inside her pants. The brief was not wet; I think that it wasn't on properly. I was pulling her brief up using the outside of her pants. When were about to get back into the van to go to correct appointment location, her pants and brief fell completely down. You could only see her legs because her shirt covered her backside, and she had on a long

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 550	Continued From page 7	F 550		

jacket. I hurried and pulled them back up because we were in a parking lot but there was no one around." The AS further stated, "I used to be a [sic] aide on the floor and I used to take care of her. She has a large stomach and if the brief isn't pulled up over her stomach or up far enough, they fall down. It is hard for her to do it because she has to use one hand to pull up her brief and the other hand is on her walker to keep her steady so she has to keep switching hands back and forth. People think that she is independent, but she really isn't because she can't keep herself steady when putting on the brief. She can't fasten the tape on the brief with one hand. She really needs help and I guess the staff think that she is more independent than she really is. Her incontinence episodes are getting more frequent. It is happening in activities and the residents are talking about her in front of her, but I redirect them but she has started to refuse to leave activities in order to get changed."

2. During a dining observation on 02/21/23 at 8:07 AM, Licensed Practice Nurse (LPN) 2 was observed standing over R25 while feeding the resident. R25 was seated in a wheelchair in the assisted dining room at the time of observation. A chair was available in the assisted dining room for LPN2's use; however, LPN2 was observed for a four-minute continuous period, to stand over the resident while feeding her. Restorative LPN3 was observed to tell LPN2 to sit while feeding the resident.

During an interview on 02/21/23 at 8:13 AM, LPN2 stated, "I didn't know to sit to feed her before because I have never fed a resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 550	Continued From page 8	F 550		

before."

Review of R25's undated "Resident Face Sheet," located in the resident's EMR under the "Resident" tab revealed the resident was admitted to the facility on 03/02/20.

Review of R25's annual "MDS," located in the resident's EMR under the "RAI" tab with an ARD of 02/09/23, revealed a "BIMS" score of 11 out of 15, indicating R25 was moderately impaired. This MDS also revealed that R25 was independent with eating.

During an interview on 02/22/23 at 10:33 AM, the SSD stated, "Staff should be seated when feeding a resident for dignity purposes."

During an interview on 02/23/23 at 10:16 AM, the Administrator stated, "My expectation would be for the staff to be seated and at eye level with the resident so there can be conversations, unless when seated and the resident would not be at eye then they are able to stand."

During an interview on 02/23/23 at 10:35 AM, Restorative LPN3 stated, "When assisting a resident to eat, the staff should be seated and at eye level."

During an interview on 02/23/23 at 10:48 AM, the Dietary Manager (DM) stated, "When feeding a resident, the staff should be seated and having conversations with the residents. I see this here all the time and they really just need to take the time to sit down with the residents."

During an interview on 02/23/23 at 11:27 AM, the DON stated, "I expect for staff to sit when they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 550	Continued From page 9 are feeding residents, unless they are feeding two residents, then they can stand and feed the two residents."	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to determine if self-administration of medication was safe and clinically appropriate for two (Resident (R) 11 and R37) of 27 sampled residents. Findings include: Review of a facility policy titled, "Self-Administration of Medication," revised 02/2013, indicated, "The facility, in conjunction with the interdisciplinary team, should assess and determine, with respect to each resident, whether self-administration of drugs is safe and appropriate." 1. a. During an observation on 02/20/23 at 1:47 PM, R11 was in her room performing her nebulizer treatment. There were no staff present during this observation. At 1:49 PM, R11 was observed turning off the nebulizer. During an interview on 02/21/23 at 9:09 AM, R11 stated that she does her nebulizer treatment three times a day. R11 stated, "The nurse put the	F 554		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 554	Continued From page 10	F 554		

solution in and then I do the treatment for about 10 minutes." When asked if she had been assessed by staff to self-administer her nebulizer, R11 stated, "No, but I know how to do it."

b. During a continuous observation on 02/21/23 at 2:03 PM, R11 was in her room performing her nebulizer treatment. There were no staff present during this observation. At 2:17 PM, R11 was observed turning off the nebulizer.

Review of R11's undated "Resident Face Sheet," located in the resident's electronic medical record (EMR) under the "Resident" tab revealed the resident was admitted to the facility on 11/01/17 with diagnoses of chronic obstructive pulmonary disease and asthma.

Review of R11's quarterly "Minimum Data Set (MDS)," located in the resident's EMR under the "RAI (Resident Assessment Instrument)" tab with an Assessment Reference Date (ARD) of 01/19/23, revealed a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15, indicating R11 was cognitively intact.

Review of R11's "Prescription Order," dated 11/07/22, located in the resident's EMR under the "Orders" tab revealed, "Ipratropium-albuterol solution for nebulization; 0.5 mg [milligrams]-3 mg (2.5 mg base)/3 mL [milliliters]; amt[amount]: 3 mL (one vial); inhalation. Three times a day." Continued review of R11's EMR revealed the absence of an order for self-administration of medication and no evidence that the facility had completed an assessment for self-administration of medication.

Review of R11's January 2023 - February 2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 554	Continued From page 11	F 554		

"Medication Administration Record," located in the resident's EMR under the "Resident" tab revealed R11 received the ipratropium-albuterol solution as ordered.

During an interview on 02/22/23 at 8:36 AM, when asked about R11's nebulizer treatments, Certified Medication Aide (CMA)1 stated, "I set the medicine up into the canister and then she likes to do them after breakfast. So, I have it already prepared in the canister. When she returns to her room, she flips on the nebulizer and does her treatment. It takes about ten minutes complete the treatment. Later, I check on her and look at canister to verify that it is empty."

2. a. During an observation on 02/20/23 at 11:02 AM, R37 was observed seated upright on the edge of her bed with a nebulizer on the bed with the resident.

b. During an observation and concurrent interview on 02/21/23 at 2:00 PM, R37 was observed seated upright on the edge of her bed with a nebulizer on the bed with the resident. When asked about the nebulizer, R37 stated, "I do it myself. The staff does the medicine and I take it off when the medicine runs out and I turn off the machine. Well, yeah, sometimes they turn it on and sometimes I do, and I always turn it off." When asked how often she is scheduled to receive the nebulizer treatment, R37 stated, "A couple of times a day." When asked if staff watched to ensure the treatment was done correctly, R37 stated, "No." When asked if staff educated her on the nebulizer treatment, R37 stated, "No, they just put in on my bed to make sure that I can reach it and they put the medicine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 554	Continued From page 12	F 554		

in."

c. During an observation on 02/22/23 at 11:12 AM, CMA1 administered R37's nebulizer medication and the treatment began at 11:17 AM. CMA1 proceed to administer medication to R37's roommate and then left the room at 11:17 AM. At 11:27 AM, R37 removed the nebulizer from her mouth, looked at the remaining medication in the holder, and placed the nebulizer back in her mouth. At 11:32 AM, R37 checked the remaining medication, laid the nebulizer on the bed, and turned the machine off. R37 stated she always self-administered her nebulizer treatment. R37 further stated she had not been assessed by the staff to determine if she could self-administer.

Review of R37's undated "Resident Face Sheet," located in the resident's EMR under the "Resident" tab revealed the resident was admitted to the facility on 10/11/19 with diagnoses of congestive heart failure and chronic respiratory failure with hypoxia.

Review of R37's quarterly "MDS," located in the resident's EMR under the "RAI" tab with an ARD of 12/29/22, revealed a "BIMS" score of 15 out of 15, indicating R37 was cognitively intact.

Review of R37's "Prescription Order," dated 11/07/22, located in the resident's EMR under the "Orders" tab revealed, "Ipratropium-albuterol solution for nebulization; 0.5 mg-3 mg (2.5 mg base)/3 mL; amt: 1 vial; inhalation. Four times a day." Continued review of R37's EMR revealed the absence of an order for self-administration of medication and no evidence of an assessment for self-administration of medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 554	Continued From page 13 Review of R37's November 2022 - February 2023 "Medication Administration Record," located in the resident's EMR under the "Resident" tab revealed R37 received the ipratropium-albuterol solution as ordered. During an interview on 02/22/23 at 8:36 AM, when asked about R37's nebulizer treatments, CMA1 stated, "I go into the room, put the medicine into the canister, I start the machine for her or sometimes she starts the machine, she does her treatment, and turns it off when she is done. I go back in later and verify the medicine has been completed." When asked about a self-administration assessment, the CMA stated, "I don't know if she has been assessed to do the medication. I think that respiratory therapy would do something with that. I have witnessed her do her treatment before." During an interview on 02/22/23 at 12:07 PM, the Director of Nursing (DON) stated, "There are not any self-administration assessments for these residents [R11 and R37]." The DON further stated that she was unaware R37 and R11 were self-administering their nebulizer treatment. The DON confirmed there were no physician orders for R37 or R11 to self-administer medications. During an interview on 02/22/23 at 12:09 PM, the Infection Preventionist (IP) and previous DON stated, "I have seen the self-administration assessments before, but we don't do those." The IP also stated she was unaware that R37 and R11 were self-administering their nebulizers.	F 554		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)	F 561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 561	Continued From page 14 §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to promote self determination to support and honor a resident's expressed desire to lose weight for one (Resident (R) 56) of five residents reviewed for nutrition out of a total sample of 27 residents. Findings include:	F 561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 561	Continued From page 15	F 561		

Review of R56's undated "Resident Face Sheet," located in the resident's electronic medical record (EMR) under the "Resident" tab revealed the resident was admitted to the facility on 04/21/22 with diagnoses including diabetes. The resident was listed as his own responsible party.

Review of R56's quarterly "Minimum Data Set (MDS)," located in the resident's EMR under the "RAI (Resident Assessment Instrument)" tab with an Assessment Reference Date (ARD) of 08/09/22, revealed a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15, indicating R56 was cognitively intact.

Review of R56's "Weights," located in the resident's EMR under the "Resident" tab revealed R56 weighed 251 pounds 08/05/2022 and 208 pounds on 02/05/2023, which was a 17.13 % (percent) weight loss in six months.

Review of R56's "Physician Orders," located in the resident's EMR under the "Resident" tab revealed the following order dated 01/28/23: "Ensure Plus Protein 1 carton Twice A Day."

Review of R56's "Progress Notes," located in the resident's EMR under the "Resident" tab revealed the following notes:

a. 02/03/23: "assessment completed. BMI [body mass index] is 34.9 and is obese. receives a house diabetic diet with regular texture. Wts [weights] stable this quarter. also receives Ensure Pro for healing and hx [history] of wt loss. has 4 wound sites. albumin is mildly depleted. monitor wts monthly and reassess quarterly."

b. 02/08/23: "has had a significant weight loss in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 561	Continued From page 16	F 561		

180 days weight is stable weight 208 BMI 34.61 he is fed by staff started on ensure plus protein for wound care and when not eating as well at time chooses to eat soup at meals will cont [continue] to encourage at meals."

c. 02/10/23: "wt loss at 180 days. wt is stable for last 30 days. approaches for wound healing and wt loss are liquacell (100 cal[calories]/ and 16 GR [gram] protein/srvg [serving]), Ensure Plus protein (360 calories and protein per srvg). receives a house diabetic diet with regular texture."

d. 02/18/23: "Noted and Dr. aware of 43# [pound] weight loss in 6 months. Res continues on House Diabetic. Appetite has been good. Meals in dining room. Weight loss had happen [sic] when res was sick and in hospital. Res aware of weight loss."

During an interview on 02/22/23 at 8:49 AM, when asked about his recent weight loss, R56 stated, "I was 250 pounds. I didn't want to be 250 pounds, so I started eating less."

During an interview on 02/22/23 at 8:44 AM, when asked about R56's weight loss, Certified Medication Aide (CMA)1 stated, "He had COVID for a while and had weight loss then. He is on Ensure twice a day and he started that on 01/28/23. Sometimes he doesn't eat his entire meal."

During an interview on 02/22/23 at 10:33 AM, the Social Services Director (SSD) stated, "He always says that he wants to lose weight. I would tell him that he was good as he was. I thought he was teasing and just talking, you know. He didn't say it aggressively but stated he wanted to lose weight, but we were worried with his wounds and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 561	Continued From page 17	F 561		

the extra protein needs." The SSD stated that she did not document R56's expressed desire to lose weight. The SSD further confirmed she did not inform the nursing staff or the dietary manager (DM) of R56's desire to lose weight.

During a follow-up interview on 02/23/23 at 10:01 AM, R56 stated he told the SSD "I wanted to lose weight. She told me that I was OK like I was, but I don't want to weigh 250 pounds, so I decided to cut back some. Now I eat soup and eggs and fruit. I lost my leg and decided I needed to do better with eating so I can get well. I don't want to be sick, and I don't want to weigh too much."

During an interview on 02/23/23 at 10:16 AM, when asked about R56's weight loss, the Administrator stated, "Yes, he has lost weight. He used to eat a lot of sweets, but I noticed that he has been eating more soups and peaches." The Administrator further stated, "I was not aware that he wanted to lose weight. I would expect that if he told someone that he wanted to lose weight, it should be documented, and we should assist him in losing weight. He should not have been brushed off. It should have been documented and taken seriously."

During an interview 02/23/23 at 10:48 AM, the Dietary Manager (DM) stated, "I did not know that he wanted to lose weight. That was not communicated with me. I documented that he was sick and lost a limb and that attributed to his weight loss. I talked with the dietician, and she added the ensure to add the extra calories. He used to love sugar and always ate his desert first. He was always asking for honey buns and such. I would always educate him but that was still his choice." The DM further stated, "After he lost his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 561	Continued From page 18	F 561		

leg, I started noticing that he was asking for different foods and wasn't eating the sweets anymore. I think that, when he had the amputation, that scared him. I saw him eating less sweets but I didn't know that he wanted to lose weight. If I had known, I would have assisted him with his weight loss."

During an interview on 02/23/23 at 10:57 AM, the Registered Dietitian (RD) stated, "The resident has had a weight loss of over 40 pounds in the last 180 days but stabilized back in November. We have him on Ensure Pro Plus Protein twice per day which adds 720 calories a day. For his wounds, we have him on Liquacel which adds 100 calories per day." The RD further stated, "I was not aware that he wanted to lose weight. If I had known, I would not have started him on the Ensure Plus but would have kept him on the Liquacel. The Ensure Plus adds an extra 720 calories. I would have addressed his weight loss differently if I had known that he wanted to lose weight. It's like a catch 22 because we are adding calories and he is eating less trying to lose the weight."

During an interview on 02/23/23 at 11:27 AM, the Director of Nursing (DON) stated she was aware of R56's weight loss but was unaware that he wanted to lose weight. The DON stated, "When a resident desires to lose weight, I expect this information to be documented and for the dietary department to come up with healthy food choices, taking his wounds into account. I fully expect the facility to assist him in losing weight. I feel like if a resident took the time to speak up for himself and tell someone that he wanted to lose weight, staff should have listened to him. I personally would have been upset if I approached someone with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 561	Continued From page 19 the want to lose weight and they didn't listen to me because apparently I wanted to lose weight and feel better about myself and went to someone expecting them to support me."	F 561		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 609	Continued From page 20	F 609		

policy review, the facility failed to report an allegation of abuse to the State Survey Agency (SSA - Iowa Department of Inspections and Appeals) within two hours for one (Resident (R) 42) of one residents reviewed for abuse out of 27 sampled residents.

Findings include:

Review of the facility's policy titled, "Abuse Prevention, Identification, Investigation and Reporting," dated 10/2022, indicated, "All allegations of Resident abuse shall be reported to the Iowa Department of Inspections and Appeals not later than two (2) hours after the allegation is made."

Review of R42's "Face Sheet," located under the "Resident" tab of the electronic medical record (EMR), indicated R42 was admitted with diagnoses that included adjustment disorder.

During an interview on 02/21/23 at 1:32 PM, R42 stated that Certified Nurse Aide (CNA) 4 and CNA5 had assisted her with personal care at some time during 12/2022 or 01/2023 and, during that care, CNA5 told CNA4 that R42 just wanted CNA4 "in her pants." R42 stated this was mental abuse. R42 stated she had informed the Director of Nursing (DON) and nothing was done.

During an interview on 02/21/23 at 1:38 PM, the DON denied any knowledge of the allegation.

During an interview on 02/21/22 at 2:23 PM, the Administrator stated she was responsible for reporting allegations of abuse at the facility. At this time, the Administrator was notified of R42's allegation of mental abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 609	Continued From page 21 During an interview on 02/22/23 at 9:51 AM, the Administrator provided a "Summary Report" of her investigation of the allegation of mental abuse that was reported to her, over 19 hours earlier. on 02/21/23 at 2:23 PM. The Administrator stated there was lack of evidence to support the allegation and, since the allegation was disproven within two hours, it did not have to be reported per Iowa state law. The Administrator confirmed the allegation of mental abuse had not been reported to the Iowa Department of Inspections and Appeals within two hours. The Administrator stated that the facility followed Iowa law and she did not know what the federal regulation was regarding reporting allegations of abuse. During an additional interview on 02/22/23 at 12:49 PM, the Administrator stated she had reviewed the federal regulation. The Administrator stated that the allegation (which alleged abuse and therefore required reporting within no more than two hours) was reported within 24 hours since it did not involve serious injury.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 610	Continued From page 22 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to conduct a thorough investigation of an allegation of mental abuse for one (Resident (R) 42) of one residents reviewed for abuse out of 27 sampled residents. The facility failed to interview or attempt to obtain a witness statement from the alleged victim. Findings include: Review of the facility's policy titled, "Abuse Prevention, Identification, Investigation and Reporting," dated 10/2022, revealed, "Should an incident or suspected incident of Resident abuse . . . be reported . . . The administrator or designee will . . . Attempt to obtain witness statements . . . from all known witnesses." Review of R42's "Face Sheet," located under the "Resident" tab of the electronic medical record (EMR), indicated R42 was admitted with diagnoses that included adjustment disorder. During an interview on 02/21/23 at 1:32 PM, R42 stated that Certified Nurse Aides (CNA) 4 and 5 had assisted her with personal care at some time during 12/2022 or 01/2023 and during that care, CNA5 told CNA4 that R42 just wanted CNA4 "in her pants." R42 stated this was mental abuse. R42 stated she had informed the Director of	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 610	Continued From page 23 Nursing (DON) and nothing was done. During an interview on 02/21/23 at 1:38 PM, the DON denied any knowledge of the incident. During an interview on 02/21/23 at 2:23 PM, the Administrator stated she was responsible for investigating allegations of abuse at the facility. At this time, the Administrator was notified of R42's allegation of mental abuse. During an interview on 02/22/23 at 9:51 AM, the Administrator provided a "Summary Report" of her investigation of R42's allegation of mental abuse. Review of the "Summary Report" indicated R42, the alleged victim, was not interviewed during the investigation. During an interview on 02/22/23 at 10:26 AM, R42 stated she had not been interviewed by any staff member regarding her allegation of mental abuse. During an additional interview on 02/22/23 at 12:58 PM, the Administrator stated she was finished with the investigation and confirmed she had not interviewed R42. The Administrator stated she did not interview R42 since the allegation of mental abuse was reported by the survey team.	F 610		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 623	Continued From page 24	F 623		

the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 623	Continued From page 25 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 623	Continued From page 26	F 623		

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of facility policy, the facility failed to provide a written notice of transfer to the resident and/or resident's representative for four (Resident (R) 30, R32, R61 and R116) of four residents reviewed for hospitalization to ensure that the resident and/or their representative were informed of all pertinent information regarding their transfer to another health facility.

Findings include:

1. Review of R30's "Face Sheet," found under the resident tab in the Electronic Medical Record (EMR), revealed an admission date of 11/28/22, with medical diagnoses that included respiratory failure and dependence on a respirator.

Review of the "Progress Notes" under the resident tab in the EMR, dated 11/25/22 at 12:34 AM, revealed, "While performing this resident's vent check, this RT [respiratory therapist] noticed an absence in lung sounds throughout. When asked if he [R30] had any difficulty breathing he said yes. RT called his nurse in to assess ... His nurse was unable to detect any breath sounds throughout ... Resident appears ashen in skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 623	Continued From page 27 tone and lethargic. He was sent to the hospital to be further evaluated." Review of the resident's clinical record revealed no evidence that a written notice, which contained all required information including the reason and effective date for the transfer, the location to which the resident was transferred, and information about the resident's appeal rights and how to contact the Long-Term Care Ombudsman, was provided to either the resident and/or their representative. 2. Review of R32's "Face Sheet," found under the resident tab in the EMR, revealed an admission date of 12/14/22 with medical diagnoses that included chronic kidney disease (stage 4) and anxiety. Review of the "Progress Notes" under the resident tab in the EMR, dated 02/20/23 at 4:13 AM revealed the resident was transferred to the hospital for vaginal bleeding. Review of the resident's clinical record revealed no evidence that a written notice, which contained all required information including the reason and effective date for the transfer, the location to which the resident was transferred, and information about the resident's appeal rights and how to contact the Long-Term Care Ombudsman, was provided to either the resident and/or their representative. 3. Review of R61's "Face Sheet," found under the	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 623	Continued From page 28	F 623		

resident tab in the EMR, revealed an admission date of 01/13/23 with medical diagnoses that included dependence on a respirator and chronic disease.

Review of the "Hospital Notes" under the resident tab in the EMR, dated 01/23/23, revealed, "pt [patient] admitted to hospital from [facility name] pt with hx [history] of anoxic brain injury - vent dependent. She presented with tachypnea pt with sepsis - looking into antibiotics and then may be able to d/c [discharge] back."

Review of the resident's clinical record revealed no evidence that a written notice, which contained all required information including the reason and effective date for the transfer, the location to which the resident was transferred, and information about the resident's appeal rights and how to contact the Long-Term Care Ombudsman, was provided to either the resident and/or their representative.

4. Review of R116's undated "Resident Face Sheet," located in the resident's EMR under the "Resident" tab revealed the resident was admitted to the facility on 04/26/21.

Review of R116's "Census Report," located in the EMR under the "Resident" tab, revealed R116 was transferred to the hospital on 06/24/21.

Review of R116's medical record revealed no evidence of a written notice of transfer to the resident and/or the resident's representative.

During an interview with Registered Nurse (RN)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 623	Continued From page 29 2, on 02/22/23 at 10:58 AM, she stated when a resident needed to go to the hospital, the resident's doctor and the resident's responsible party would be notified verbally. RN2 stated she was not aware of any paperwork that was provided to the resident or their responsible party when the resident was sent to the hospital that explained the reason for the transfer to the hospital. During an interview with the Director of Nursing (DON), on 02/22/23 at 11:30 AM, she stated the facility did not complete a discharge or transfer form and was unaware one was required per regulation. During an interview with the Administrator, on 02/22/23 at 12:07 PM, she stated the facility did not use a transfer form when a resident was sent to the hospital and was not aware one was needed. The Administrator stated the facility did not have a policy for this requirement but would be implementing one.	F 623		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the	F 637		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 637	Continued From page 30 care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete a significant change assessment for one (Resident (R) 42) of one sampled resident who experienced a significant change in status out of 27 sampled residents. A significant change (comprehensive) assessment was not completed after R42 was hospitalized for suicidal ideation and assessed as requiring specialized services. Findings include: Review of R42's "Face Sheet," located under the "Resident" tab of the electronic medical record (EMR), indicated R42 was admitted with diagnoses that included adjustment disorder. Review of R42's "Progress Note," dated 09/22/22 and located under the "Resident" tab of the EMR, indicated R42 was hospitalized for psychiatric care after verbalizing suicidal ideations. Review of R42's "PASRR [Preadmission Screening and Resident Review] Level II Outcome Explanation," dated 10/13/22 and located under the "Resident" tab of the EMR, indicated R42 required specialized services due to her behavioral health conditions. Review of R42's Minimum Data Set (MDS) assessments indicated the facility completed a quarterly MDS assessment with an Assessment Reference Date (ARD) of 10/13/22. Review of this quarterly MDS, as well as the resident's MDS assessment history, revealed the facility did not complete a significant change assessment for	F 637		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 637	Continued From page 31 R42 following her 09/22/22 hospitalization for suicidal ideations and PASRR Level II assessment which indicated the need for specialized services. During an interview on 02/23/23 at 4:05 PM, the MDS Coordinator (MDSC) stated R42's hospitalization and need for specialized services was a significant event that qualified for a significant change (comprehensive) assessment and confirmed one was not done. The MDSC stated the facility's policy on significant change assessments was to follow the regulations.	F 637		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that four (Resident (R) 30, 42, 56 and 21) of 31 residents (27 sampled and four supplemental residents) had Minimum Data Set (MDS) assessments completed in accordance with instructions from the Resident Assessment Instrument (RAI) 3.0 User's Manual. Residents who could communicate and answer questions were not interviewed by facility staff to determine their cognitive and/or mood status. Staff made their own determination in these areas, and inaccurately reflected residents' cognitive status. Findings include: Review of the RAI 3.0 User's manual, dated 10/2019, revealed the following instructions	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 641	Continued From page 32	F 641		

related to Section C (Cognitive Patterns), "The RAI assessment process is the basis for the accurate assessment of each resident ...Most residents are able to attempt the Brief Interview for Mental Status. A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance. Without an attempted structured cognitive interview, a resident might be mislabeled based on his or her appearance or assumed diagnosis." Instructions for C0100 included the statement, "Should Brief Interview for Mental Status be conducted? Attempt to conduct interview with all residents." Further instructions for Section C revealed the instruction, "Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted, but was not done. "

Instructions for Section D (Mood) revealed the following information: "Should Resident Mood Interview be conducted? Attempt to conduct interview with all residents ....Do not complete the Staff Assessment of Resident Mood items (D0500) if the resident interview should have been conducted, but was not done."

1. Review of R42's "Face Sheet," located under the "Resident" tab of the electronic medical record (EMR), indicated R42 was admitted with diagnoses that included adjustment disorder.

a. Review of R42's "Progress Notes," dated 10/01/22 through 10/12/22 and located under the "Resident" tab of the electronic medical record (EMR), indicated R42 was alert, oriented, and capable of answering questions related to mental status and mood.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 641	Continued From page 33 Review of R42's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/13/22 and located under the RAI (Resident Assessment Instrument) tab of the EMR indicated staff did not conduct the "Brief Interview for Mental Status" in the "Cognitive Patterns" section of the MDS. Although the resident was capable of answering questions, staff instead conducted the "Staff Assessment for Mental Status" and coded R42 as having modified independence in cognitive skills for daily decision making. In addition, staff failed to conduct the "Resident Mood Interview" in the "Mood" section of the MDS, and instead completed the "Staff Assessment of Resident Mood" instead. b. Review of R42's "Progress Notes," dated 01/01/23 through 01/11/23 and located under the "Resident" tab of the EMR, indicated R42 was alert, oriented, and capable of answering questions related to mental status and mood. Review of R42's quarterly MDS with an ARD of 01/12/23 and located under the RAI tab of the EMR revealed staff did not conduct the "Brief Interview for Mental Status" in the "Cognitive Patterns" section of the MDS. Instead, staff completed the "Staff Assessment for Mental Status" and coded R42 as being moderately impaired in cognitive skills for daily decision making. In addition, it was indicated that staff did not conduct the "Resident Mood Interview" in the "Mood" section of the MDS but conducted the "Staff Assessment of Resident Mood" instead. Review of R42's "Progress Note," dated 01/16/23 at 12:33 PM and located under the "Resident" tab	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 641	Continued From page 34	F 641		

of the EMR, indicated, "SS [Social Services] completed MDS based off of Resident progress notes, observations and documentation."

During an interview on 02/22/23 at 10:31 AM, the MDS Coordinator (MDSC) stated, "Section C is handled by our Social Services Director (SSD). She is the one that actually inputs the cognition data into the system."

During an interview on 02/23/23 at 3:39 PM, the SSD confirmed R42 was capable of answering the cognitive and mood interview questions on the 10/13/22 MDS. The SSD stated she attempted to interview R42 and R42 had asked her to come back at a different time, but she could not as the assessment was due on that day. Further interview with the SSD confirmed that R42 was also capable of answering the cognitive and mood interview questions on the 01/12/23 MDS. However, the SSD had completed the staff assessment instead, based on progress notes, observations, and documentation. The SSD stated she did not remember if R42 had been sleeping but she did not document that R42 refused the interview. The SSD stated it was best practice for residents to participate in the interviews and she had not been reporting when residents did not participate in the interviews.

During an interview on 02/23/23 at 4:05 PM, the MDS Coordinator (MDSC) confirmed it was her job to monitor the accuracy of the MDS and it was the facility's policy to follow regulations related to MDS accuracy. The MDSC stated staff had six to eight days to complete their sections of the MDS and that allowed ample to conduct resident interviews.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 641	Continued From page 35	F 641		

2. Review of R56's undated "Resident Face Sheet," located in the resident's EMR under the "Resident" tab revealed the resident was admitted to the facility on 04/21/22.

Review of R56's quarterly "MDS," located in the resident's EMR under the "RAI" tab with an ARD of 08/09/22, revealed a "BIMS" score of 14 out of 15, indicating R56 was cognitively intact.

Review of R56's quarterly MDS assessments, with ARDs of 11/03/22 and 02/02/23, revealed these two assessments were not conducted in accordance with instructions from the RAI manual. Although the resident was able to communicate and answer questions, staff failed to conduct the resident interview to determine the BIMS score of this resident. Instead, for these MDS assessments, staff completed their own determination of the resident's mental status. Further review of these MDS, revealed that although the resident had previously been identified as cognitively intact, on both the 11/03/22 and 02/02/23 MDS, staff now documented the resident was moderately cognitively impaired.

Review of R56's "Resident Progress Notes," dated 11/03/22, written by the SSD, located in the resident's EMR under the "Resident" tab revealed the following: "SS [Social Services] completed MDS based off of Documentation and interactions. Res [resident] was presently unavailable due to an appointment."

During an interview on 02/22/23 10:33 AM, the SSD stated that R56 was very talkative and had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 641	Continued From page 36	F 641		

good memory recall. The SSD further stated that R56 was alert and oriented times three except when he is sick and his cognition lowers. When asked if R56 was sick during the time of the 02/02/23 MDS assessment, the SSD stated R56 was not sick. When asked why R56's BIMS was not assessed on the MDS assessment, the SSD stated, "I put 'not assessed/no information' and I did the staff assessment portion. That's what I put in if I didn't get a chance to do the cognitive questions, like if he was asleep or not able to participate. I should have documented how many attempts I made to talk to him so that we could have the BIMS score reflect accurately. I usually attempt three times." The SSD further stated, "It [BIMS] should have been completed on him. I didn't document why so not sure why I didn't do it that day." When asked about the 11/03/22 MDS assessment, the SSD stated, "That one should have been done also. I put a note in for November that he was at doctor's appointment." The SSD further stated that when the MDSC "opens the assessment, they are open for a day or two and that is our timeframe to put in the information." The SSD stated, "Just because he was not in the facility at that moment, I should have went [sic] back and checked again in order to complete his BIMS." When asked why the staff assessment portion that the SSD completed reflected R56's cognition to be moderately impaired, (equivalent to a BIMS score of between eight through 12,) the SSD stated, "I should have put that he was cognitively intact. His BIMS score is normally a 14 or 15."

During an interview on 02/22/23 at 2:13 PM, the MDSC stated, "When staff are to assess the residents, I leave the MDS open from Monday - Friday or from Friday - Friday so that the staff can

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 641	Continued From page 37	F 641		

have time to input the data. I expect the sections to be completed accurately and I expect the staff to attempt to see resident at least three to four times in order to get the assessment completed accurately."

3. Review of R21's undated "Resident Face Sheet," located in the resident's EMR under the "Resident" tab revealed the resident was admitted to the facility on 03/30/17.

Review of R21's quarterly "MDS," located in the resident's EMR under the "RAI" tab with an ARD of 11/03/22, revealed a "BIMS" score of 15 out of 15, indicating R21 was cognitively intact.

Review of R21's annual MDS, with an ARD of 02/02/23, revealed this assessment was not conducted in accordance with instructions from the RAI manual. Staff failed to conduct the resident interview to determine the BIMS score of this resident, who was able to communicate and answer questions. Instead, staff completed their own determination of the resident's mental status. Further review of this MDS revealed that although the resident was previously assessed as cognitively intact on the 11/03/22 MDS, the resident was now documented as being moderately cognitively impaired..

During an interview 02/23/23 at 3:26 PM, the SSD stated that R21 "was alert and oriented times three." When asked why R21's BIMS was not assessed on the MDS assessment, the SSD stated, "I didn't put a note why it wasn't done." The SSD confirmed R21 was available at the facility during the time the MDS was due and had no answer as to why the BIMS was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 641	Continued From page 38	F 641		

completed. When asked why the staff assessment portion that the SSD completed reflected R21's cognition to be moderately impaired (reflecting an equivalent BIMS score of between eight through 12), the SSD stated, "Her BIMS score is normally 15." The SSD stated that although there was no change in the resident's cognition, she scored it lower when she completed her assessment. The SSD was unable to answer why she reflected R21's BIMS inaccurately.

4. Review of R30's "Face Sheet," found under the resident tab in the EMR, revealed an admission date of 11/28/22 with medical diagnoses that included respiratory failure and dependence on a respirator.

Review of R30's quarterly "MDS," provided by the facility, with an ARD of 10/27/22, revealed a "BIMS" score of 15 out of 15, indicating R30 was cognitively intact. Review of the most recent MDS, with an ARD of 01/26/23, revealed that although the resident could communicate and answer questions, staff failed to interview the resident to complete the BIMS score or mood assessment. Instead, review of the 01/26/23 MDS revealed that staff completed the assessment of these areas with no staff interview.

During an interview with the social services director (SSD), on 02/23/23 at 1:47 PM, she stated she was responsible for completing section C, D, E, Q, and Z of the MDS. The SSD stated she would be notified when the MDS needed to be completed, based on the weekly list provided by the MDSC. She stated she would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 641	Continued From page 39 typically try three times to interview the resident in case they were out at an appointment or asleep. She stated she would document in the progress note if the resident was not available for the interview. The SSD confirmed the resident interviews for section C (Cognitive) and Section D Mood) were not completed for the ARD of 01/26/23 and there was no documentation indicating why these portions of the MDS were not completed. She stated R30's cognition had not changed and R30 was interviewable. During an interview with the MDS Coordinator (MDSC), on 02/23/23 at 2:15 PM, she stated she would send out a weekly list indicating which MDS were due the following week. She stated she would leave the MDS open for seven days and would verify all departments had completed their portion of the MDS. She stated she expected the MDS to be accurate but did not verify accuracy of sections that were completed by other staff.. During an interview with the Administrator and the Director of Nursing, on 02/23/23 at 2:29 PM, they stated they expected all sections of the MDS to be completed accurately. During an interview 02/23/23 at 2:40 PM, the Administrator stated, "We do not have a MDS policy. We follow the RAI manual."	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 656	Continued From page 40	F 656		

resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 656	Continued From page 41 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a behavioral health comprehensive care plan for one (Resident (R) 42) of one residents reviewed for behavioral health concerns out of 27 sampled residents. Findings include: Review of R42's "Face Sheet," located under the "Resident" tab of the electronic medical record (EMR), indicated R42 was admitted with diagnoses that included adjustment disorder. Review of R42's "Progress Note," dated 09/22/22 and located under the "Resident" tab of the EMR, indicated R42 was hospitalized for psychiatric care after verbalizing suicidal ideations. Review of R42's "Notice of PASRR [Preadmission Screening and Resident Review] Level II Outcome," dated 10/13/22 and located under the "Resident" tab of the EMR, indicated, "The nursing facility will be required to Care Plan in a PASRR compliant fashion for all identified services including Specialized Services . . . you have a mental health diagnosis of recurrent, severe major depressive disorder . . . you have a history of self-harm . . . you shared that you are lonely, you spend most of your time in bed in your room, you miss the one-to-one interaction you had when you lived with your family, you get anxious and depressed due to your ongoing medical conditions and being in a nursing facility . . . Staff arguing with you . . . You stop doing the things you like to do and get angry very easily	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 656	Continued From page 42	F 656		

when you are not doing well. Going outside or having someone to talk with helps you feel better when you are having a hard time . . . We learned that the following things are important to and for you: You shared that you enjoy arts, crafts, drawing, drinking liquor, being outside, getting out of the nursing facility, listening to music, playing games on your phone, shopping, and watching Netflix . . . A good day is a day spent watching Netflix and talking with people . . . Going outside or talking with someone cheers you up when you feel down . . . Staff at Mississippi Valley Healthcare & Rehabilitation Center are encouraged to continue to learn about what you do and do not like, what your hobbies are, and how you like to spend your time . . . You will need to be provided . . . Development by the nursing facility in conjunction with the individual and behavioral health providers of a Crisis Intervention/Safety Plan to identify triggers and symptoms, best methods for management of challenges, action steps to be taken by all parties in order to reduce risk of hospitalization . . . Socialization/leisure/recreation activities appropriate to current skills or adapted to facilitate optimal participation . . . Supportive counseling from NF [nursing facility] staff . . . Because you get lonely and you have been anxious and depressed, will benefit from the support of staff to help . . . you manage your behavioral symptoms."

Review of R42's "Care Plan," revised 01/23/23 and located under the "RAI (Resident Assessment Instrument)" tab of the EMR, indicated R42 had a problem related to adjustment disorder. The goal was listed as learning to cope with stressful situations in a healthy manner and interventions were to monitor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 656	Continued From page 43	F 656		

for hopelessness, insomnia, anxiety, anger, disruptive behavior, depressed mood, headaches, loss of appetite, withdrawing from social environment, and suicidal thoughts. There were no individualized interventions listed for R42. The care plan did not address the PASRR requirements or R42's need for specialized services, crisis plan, interventions to assist R42 in managing any behavioral symptoms, the episode of suicidal ideation requiring hospitalization, or previous attempts at self-harm.

During an interview on 02/23/23 at 10:48 AM, the MDS Coordinator (MDSC) stated the Social Services Director (SSD) was responsible for ensuring behavioral concerns were addressed on the care plan. The MDSC confirmed R42's care plan did not address behaviors, specialized services, past mental health issues, crisis plan, or contain interventions related to R42's behavioral health. The MDSC confirmed the behavioral care plan should have been included in R42's plan of care.

During an interview on 02/23/23 at 9:43 AM, the Social Services Director (SSD) confirmed R42's care plan did not address behaviors, specialized services, past mental health issues, crisis plan, or contain interventions related to R42's behavioral health. The SSD stated she had focused on R42's crisis plan but confirmed R42's care plan should have addressed her behavioral health concerns.

During an interview on 02/23/23 at 4:16 PM, the Administrator stated the facility's policy on developing comprehensive care plans was to follow the regulations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 657	Continued From page 44	F 657		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure Registered Nurses (RN) and/or Certified Nurse Aides (CNAs) with resident responsibilities were involved in the care planning process for three (Resident (R) 42, 56, and 30) of 27 sampled residents.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 657	Continued From page 45 Findings include: 1. Review of R42's "Face Sheet," located under the "Resident" tab of the electronic medical record (EMR), indicated R42 was admitted with diagnoses that included adjustment disorder. Review of R42's "Care Plan," last reviewed and revised 01/23/23 and located under the "RAI (Resident Assessment Instrument)" tab of the EMR, revealed no evidence that an RN or CNA with responsibility for the resident was involved in the care planning process. During an interview on 02/23/23 at 9:32 AM, CNA3 stated she worked with R42 frequently. CNA3 stated the CNAs did not attend care plan meetings for R42 or any resident and had never been asked for input into any resident's care. During an interview on 02/23/23 at 9:37 AM, RN1 stated she had been responsible for R42 since 10/2022. RN1 stated she did not attend care plan meetings for R42 or any resident and had not been asked to provide input into the care planning process for any resident. RN1 stated the floor nurses did not attend care plan meetings. 2. Review of R56's undated "Resident Face Sheet," located in the resident's EMR under the "Resident" tab revealed the resident was admitted to the facility on 04/21/22. Review of R56's "Care Plan," dated 01/20/23 located in the resident's EMR under the "RAI" tab revealed R56's most recent care conference was on 02/14/23. Review of R56's care plan information revealed no evidence that a CNA or RN participated in the resident's care planning	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 657	Continued From page 46 process. 3. Review of R30's "Face Sheet" found under the resident tab in the Electronic Medical Record (EMR), revealed an admission date of 11/28/22, with medical diagnoses that included respiratory failure and dependence on a respirator. Review of R30's "Care Plan," found under the resident tab in the EMR, revealed it was last revised on 01/23/23 by the Minimum Data Set Coordinator (MDSC). Further review of the care plan information revealed no evidence that a CNA was involved as part of the interdisciplinary team who developed/revised the care plan. During an interview on 02/23/23 at 10:48 AM, the MDSC stated the facility held weekly care plan meetings where she and representatives from the activities, dietary, restorative, and social services departments met to review and revise the residents' care plans. The MDSC stated she tried to talk with the CNAs before any care plan meeting, but confirmed the floor nurses and CNAs were not involved in the care planning process for any resident. On 02/23/23 at 4:16 PM, the Administrator stated the facility's policy for the care planning process was to follow the regulations.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 688	Continued From page 47	F 688		

range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

§483.25(c)(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.

§483.25(c)(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, interview, record review, and review of facility policy, the facility failed to ensure appropriate treatment and services to maintain or prevent a decline in range of motion for one (Resident (R) 41) of two residents sampled for limited range of motion (ROM) in a total sample of 27 residents. R41 was not consistently provided a splint in accordance with physician orders and her restorative program. This failure had the potential for the resident's contracted hand to have a decline in range of motion.

Findings include:

Review of a facility policy titled, "Restorative Nursing Services," dated 03/2016, indicated, "Under the guidance of the Director of Nursing (DON) or designee, the facility shall provide restorative nursing services that assist residents in achieving and/or maintaining the highest possible degree of functioning, self-care, and. independence and shall be based upon resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 688	Continued From page 48 choice, where practicable." During an observation and concurrent interview on 02/20/23 at 11:05 AM, R41 was observed seated in her room. The resident's right hand was contracted. R41 stated she had four strokes and normally wears a splint. R41 stated, "I haven't worn it in two weeks." R41 further stated the restorative aide usually puts the splint on daily for her but had not done so lately. When asked if her contracted had gotten worse, R41 stated that it had not. R41 stated, "Because of all the straps, I can't put in on by myself and I need to wear it because I can't open this hand on my own." R41's splint was observed near her windowsill at this time. During observations on 02/20/23 at 1:50 PM, 02/21/23 at 9:15 AM, and 02/21/23 1:59 PM, R41's splint remained in the same location near her windowsill and was not in use on the resident's contracted hand. Review of R41's undated "Resident Face Sheet" located in the EMR under the "Resident" tab, revealed R41 was admitted to the facility on 07/11/19 with diagnoses which included cerebral infarction. Review of R41's quarterly "MDS (Minimum Data Set)" located in EMR under the "RAI (Resident Assessment Instrument)" tab with an Assessment Reference Date (ARD) of 01/05/23 revealed R41's a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15, indicating R41 was cognitively intact. Review of R41's "Physician Order Report" located in the resident's electronic medical record (EMR)	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 688	Continued From page 49	F 688		

under the "Resident" tab, revealed the following order dated 02/19/21: "Nursing order - Heat application w [with]/ RUE [right upper extremity] PROM [passive range of motion] & prior to splint application w/ Restorative Therapy."

During an interview and concurrent review of R41's "Restorative Programs" log, on 02/21/23 at 10:49 AM, Restorative Licensed Practical Nurse (LPN) 3 confirmed R41's participation in the restorative nursing program. Restorative LPN3 stated, "We are to see her three times a week. The splint should be placed every day but a minimum of three times a week." Restorative LPN3 confirmed that R41 was unable to put on her splint independently. When reviewing the "Restorative Programs" weekly logs from 12/26/22 through 2/17/23, Restorative LPN3 identified that R41 had 24 opportunities to receive restorative nursing and splint placement as ordered, but only received these services nine times. Restorative LPN3 confirmed that R41 never refused restorative nursing assistance and the biggest gap in care was from 01/09/23 - 01/31/23, where R41 did not receive restorative nursing and splint placement during that time.

During an interview on 02/21/23 at 12:31 PM, the Certified Occupational Therapist Aide (COTA) stated, "It looks as if she had the splint before she came to us. Since she has had it for so long, I would expect it to be worn two hours per shift, every day."

During an interview on 02/23/23 at 10:16 AM, the Administrator stated, "I expect for a resident that is on the restorative nursing program to receive the required services."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 688	Continued From page 50 During an interview on 02/23/23 at 11:27 AM, the Director of Nursing (DON) stated, "I expect residents to get restorative as scheduled." The DON confirmed Restorative LPN3 was the lead on the restorative nursing program and that the program fell under her "overall umbrella." The DON further stated, "I wasn't aware that the resident had a splint until it was mentioned to me on yesterday. Since she has the splint, she should be wearing it for her contracture."	F 688		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to develop and implement individualized care plans for behavioral health concerns for one (Resident (R) 42) of one sampled resident reviewed for behavioral health concerns out of 27 sampled residents. The facility failed to thoroughly assess the resident's mood/cognition and care plan related to R42's behavioral health needs. Level II Preadmission Screening and Resident Review (PASRR) recommendations were not acted on. A crisis plan for R42, who had verbalized suicidal	F 740		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 740	Continued From page 51	F 740		

ideation, was not available for staff use. Staff were unaware and/or did not implement actions designed to improve the resident's mood/mental health.

Findings include:

Review of the facility's policy titled, "Suicide Threats," revised 03/2013, indicated, "Positive Helping Relationships . . . Be available, be there and willing to listen. Many individuals in a suicide dilemma have never encountered anyone who really wanted to hear them and understand what they really feel . . . Encourage talking: As frequently as possible; not necessary for these periods to be lengthy but they should provide the person an opportunity for ventilation . . . Provide positive human contact: Human relating that alleviates distress builds or rebuilds the hopeful expectation that other human relationships may also be helpful and fulfilling."

Review of R42's "Face Sheet," located under the "Resident" tab of the electronic medical record (EMR), indicated R42 was admitted with diagnoses that included adjustment disorder.

Review of R42's "Progress Note," dated 09/22/22 and located under the "Resident" tab of the EMR, indicated R42 was hospitalized for psychiatric care after verbalizing suicidal ideations.

Review of R42's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/13/22 revealed staff failed to conduct the "Brief Interview for Mental Status" in the "Cognitive Patterns" section of the MDS or the "Resident Mood Interview" in the "Mood" section of the MDS. Although the resident could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 740	Continued From page 52	F 740		

communicate/answer questions, staff instead conducted the "Staff Assessment for Mental Status" and "Staff Assessment of Resident Mood." (Cross -reference F641 for failure to complete MDS in accordance with assessment instructions.) Staff coded R42 as having modified independence in cognitive skills for daily decision making, and diagnoses of anxiety and depression.

Review of R42's "Notice of PASRR [Preadmission Screening and Resident Review] Level II Outcome," dated 10/13/22 and located under the "Resident" tab of the EMR, indicated, "The nursing facility will be required to Care Plan in a PASRR compliant fashion for all identified services including Specialized Services . . . you have a mental health diagnosis of recurrent, severe major depressive disorder . . . you have a history of self-harm . . . you shared that you are lonely, you spend most of your time in bed in your room, you miss the one-to-one interaction you had when you lived with your family, you get anxious and depressed due to your ongoing medical conditions and being in a nursing facility . . . Staff arguing with you . . . You stop doing the things you like to do and get angry very easily when you are not doing well. Going outside or having someone to talk with helps you feel better when you are having a hard time . . . We learned that the following things are important to and for you: You shared that you enjoy arts, crafts, drawing, drinking liquor, being outside, getting out of the nursing facility, listening to music, playing games on your phone, shopping, and watching Netflix . . . A good day is a day spent watching Netflix and talking with people . . . Going outside or talking with someone cheers you up when you feel down . . . Staff at Mississippi Valley

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 740	Continued From page 53	F 740		

Healthcare & Rehabilitation Center are encouraged to continue to learn about what you do and do not like, what your hobbies are, and how you like to spend your time . . . You will need to be provided . . . Development by the nursing facility in conjunction with the individual and behavioral health providers of a Crisis Intervention/Safety Plan to identify triggers and symptoms, best methods for management of challenges, action steps to be taken by all parties in order to reduce risk of hospitalization . . . Socialization/leisure/recreation activities appropriate to current skills or adapted to facilitate optimal participation . . . Supportive counseling from NF [nursing facility] staff . . . Because you get lonely and you have been anxious and depressed, will benefit from the support of staff to help . . . you manage your behavioral symptoms."

Review of R42's "Care Plan," revised 01/23/23 and located under the "RAI (Resident Assessment Instrument)" tab of the EMR, indicated R42 had a problem related to adjustment disorder. The goal was listed as learning to cope with stressful situations in a healthy manner and interventions were to monitor for hopelessness, insomnia, anxiety, anger, disruptive behavior, depressed mood, headaches, loss of appetite, withdrawing from social environment, and suicidal thoughts. There were no individualized interventions listed for R42. The care plan did not address R42's PASRR recommendations, the need for specialized services, crisis plan, or interventions to assist R42 in managing any behavioral symptoms. The care plan had not been updated to include the episode of suicidal ideation requiring hospitalization or previous attempts at self-harm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 740	Continued From page 54	F 740		

During an observation on 02/20/23 at 12:25 PM, Licensed Practical Nurse (LPN) 2 entered R42's room, provided education to R42 on the importance of repositioning, and left the room. LPN2 did not attempt to converse with R42 except to educate her on repositioning.

During an observation on 02/20/23 at 12:28 PM, an unidentified staff member entered R42's room, placed R42's noon meal on the bed, and left the room. The staff member did not attempt to converse with R42.

During an interview on 02/21/23 at 1:32 PM, R42 stated she did not like living at the facility, it was depressing, and it had caused her to be hospitalized at the psychiatric hospital. R42 stated staff argued with her and no one came just to talk with her.

During an interview on 02/23/23 at 9:32 AM, Certified Nurse Aide (CNA) 3 stated R42 had continuous verbal behaviors, refused care, and boycotted sleeping in her bed. CNA3 stated she would continue to ask R42 if she wanted care, attempt to direct her to other things and reapproach her in a different way when she was having behaviors. CNA3 stated she had not received any training or direction from her supervisor on how to care for R42 related to R42's behavioral health.

During an interview on 02/23/23 at 9:37 AM, Registered Nurse (RN)1 stated R42 had verbalized in the past that she wanted to die, and the main problem now was R42 did not want to get out of her wheelchair and sleep in her bed. RN1 stated staff was supposed to educate R42,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 740	Continued From page 55	F 740		

document her behaviors, and continue to educate her. RN1 stated she instructed the CNAs to check on R42 at least every two hours and ask R42 if she wanted to lie down. RN1 stated she did not attend R42's care plan meetings and had not been asked to provide any input into R42's treatment plan. RN1 stated she had not received any direction on interventions related to R42's behavioral health.

During an interview on 02/23/23 at 10:48 AM, the MDS Coordinator (MDSC) stated the Social Services Director (SSD) was responsible for ensuring behavior items were addressed on the care plan. The MDSC confirmed R42's care plan did not address behaviors, specialized services, past mental health issues, crisis plan, or contain interventions related to R42's behavioral health. The MDSC confirmed the behavioral care plan should have been included in R42's plan of care.

Continuing with the interview, the MDSC stated the interdisciplinary group talked about R42's behaviors during morning meetings and R42's progress notes were reviewed at that time. The MDSC stated they had been focusing on the documentation in the progress notes. The MDSC confirmed she should have made sure there was a behavioral care plan. The MDSC stated staff was verbally informed of any interventions that were identified for R42. The MDSC stated that she and representatives from the dietary, activities, social services, and restorative departments were involved in the care planning process. The MDSC stated the floor nurses and aides were not involved in this process

During an interview on 02/23/23 at 9:43 AM, the Social Services Director (SSD) stated when the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 740	Continued From page 56	F 740		

results of R42's Level II PASRR were received, R42 was referred to a psychiatrist and counseling. The SSD stated other recommendations were to develop a crisis plan, obtain past medical records related to R42's mental health, staff was to provide supportive counseling, and assist in pursuing community placement. The SSD attempted to open the electronic copy of the crisis plan and stated, "It's blank. It doesn't even show." The SSD stated a paper copy of the crisis plan was kept in a notebook at each nurses' station. The SSD stated she obtained R42's mental health records when R42 was admitted to the facility and with each psychiatrist and counselor visit. The SSD stated the staff was providing supportive counseling through interaction and encouraging R42 to take care of herself. The SSD stated the only individualized information the staff received about R42 was the crisis plan. The SSD stated the staff was educated on behavioral health in general during staff meetings but no education specific to R42 had been delivered. The SSD stated she had reviewed R42's mental health records and determined some interventions were to let R42 speak and to not be argumentative with R42. The SSD stated she had only talked with supervisory staff about these interventions, and the interventions were listed on R42's crisis plan.

Continuing with the interview, the SSD stated any staff who was caring for R42 had access to the paper copy of the crisis plan located at the nurses' station and they would know there was a crisis plan if their supervisors had informed them of such. The SSD stated the crisis plan was not included in R42's care plan, confirmed that it should have been, and stated it was her responsibility to ensure it was. The SSD stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 740	Continued From page 57 the crisis plan had been discussed at R42's care plan meeting but that nurses and CNAs were never at the care plan meetings. During an observation on 02/23/23 at 10:24 AM with the SSD, no copy of R42's crisis plan was observed in the "Behavior Crisis/PASRR Plans" notebook at the nurses' station for R42. The SSD stated R42's crisis plan was supposed to be in the notebook. During an interview on 02/23/23 at 11:19 AM, the Director of Nursing (DON) stated R42 had verbal behaviors, resisted care, and lashed out at staff. The DON stated there were multiple problems with R42 even though education had been provided. The DON stated staff was verbally educated to not argue with R42 and to follow their chain of command if problems were encountered with R42.	F 740		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 756	Continued From page 58 (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure medication regimen reviews addressed gradual dose reductions for psychotropic medications and/or as needed (PRN) anti-anxiety medications ordered for longer than 14 days for two (Resident (R) 11 and 49) of five sampled residents reviewed for unnecessary medications. Findings include: 1. Review of the facility's policy titled, "Anxiolytic [anti-anxiety] Medication Renewal," revised 01/2022, revealed "PRN anxiolytic medication orders must be limited to 14 days unless	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 756	Continued From page 59	F 756		

prescriber believes it is necessary for a longer duration and documents the clinical rationale and duration . . . Consultant Pharmacist will monitor compliance with monthly chart review of the resident's records."

Review of R49's "Face Sheet," located under the "Resident" tab of the electronic medical record (EMR), indicated R49 was admitted with diagnoses that included ventilator dependence and chronic kidney disease.

Review of R49's "Physician Order," dated 12/13/22 and located under the "Resident" tab of the EMR, indicated R49 was to receive lorazepam, an anti-anxiety medication, 0.5 milligrams (mg) every eight hours as needed for anxiety through 03/12/23. This was for longer than 14 days after the order was written.

Review of R49's "Progress Notes," dated 12/13/22 through 02/20/23 and located under the "Resident" tab of the EMR, revealed no documentation the Consultant Pharmacist identified the discrepancy or made a recommendation related to R49's PRN lorazepam order exceeding 14 days.

On 02/23/23 at 12:30 PM, the Consultant Pharmacist confirmed she had not sent a recommendation to the physician regarding R9's lorazepam order. The Consultant Pharmacist stated she checked the orders to ensure there was a stop date and if so, she did not make a recommendation, even if the order lasted more than 14 days.

2. Review of facility policy titled, " Consultant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 756	Continued From page 60	F 756		

Pharmacist/Medication Review Policy," dated 05/2017, indicated, "The consultant pharmacist documents activities performed and services provided on behalf of the residents and the facility. Resident-specific recommendations are documented and provided to the director of nursing to review and forward to the appropriate physician."

Review of R11's undated "Resident Face Sheet," located in the resident's EMR under the "Resident" tab revealed the resident was admitted to the facility on 11/01/17 with diagnoses of anxiety disorder and major depressive disorder.

Review of R11's "Prescription Order," dated 11/07/22, located in the resident's EMR under the "Orders" tab revealed the following orders dated 06/29/21 and 11/18/21, respectively: "Venlafaxine [antidepressant] 225 mg [milligrams]; Ativan [lorazepam - an antianxiety medication] - 0.5 mg; amt [amount]: 1/2 tab [tablet]"

Review of R11's "Physician Recommendation," dated 10/19/21, located in the resident's EMR under the "Resident" tab revealed a gradual dose reduction (GDR) for Ativan was agreed upon by the physician on 10/29/21. Review of "Physician Recommendation," dated 11/29/21 revealed a GDR for Venlafaxine was agreed upon by the physician on 12/01/21. Review of R11's complete medical record showed no additional pharmacy recommendations for R11's Venlafaxine or Ativan since 2021.

During an interview on 02/22/23 at 12:07 PM, the Director of Nursing (DON) stated, "We do not have the pharmacy recommendations for the Ativan and Venlafaxine." The DON confirmed,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 756	Continued From page 61	F 756		

"The last pharmacy recommendation for those medications are from 2021."

During an interview on 02/22/23 at 12:09 PM, the Infection Preventionist (IP) and previous DON stated, "We do not have any more recent pharm recommendations. I talked to the pharmacist, and she stated that she did not have to send those. She stated that is not what the regulations state."

During an interview on 02/22/23 at 11:28 AM, the Consultant Pharmacist stated, "There are no pharmacy recommendations for the Ativan or the Venlafaxine for 2022. I haven't sent those because the regulation states as long as the resident is assessed, I don't have to send the recommendation over. She sees a psychiatrist regularly and I've been reading the notes and the psychiatrist stated she was stable on her medication. There were notes from 10/07/22 and 06/02/22 and that is why I didn't send the recommendations."

Review of R11's psychiatric notes revealed no evidence that a further attempt at a GDR was contraindicated. The psychiatric note dated 06/02/22, located in the resident's EMR under the "Resident" tab revealed, "Discussed current medication regimen and options for depression, anxiety, and insomnia. Continue the ... venlafaxine ... as prescribed. Indications and side effects reviewed and discussed. She [R11] is agreeable to this medication regimen." Review of a psychiatric note dated 10/07/22 revealed, "Moods is improving. Remains with depressed moods at times. Appetite decreased. Sleep good. Decreased anxious and irritable moods. Plan adjust medication." (Cross-reference F758.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 758	Continued From page 62	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 758	Continued From page 63	F 758		

prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and facility policy review, the facility failed to ensure that one (Resident (R) 11) of five sampled residents reviewed for unnecessary medications received ongoing gradual dose reductions of psychotropic medications. In addition, one (R49) of the five sampled residents reviewed for unnecessary medications had an order for an as needed (PRN) anti-anxiety (anxiolytic) medication for longer than 14 days without a documented rationale.

Findings include:

1. Review of the facility's policy titled, "Anxiolytic Medication Renewal," revised 01/2022, indicated, "PRN anxiolytic medication orders must be limited to 14 days unless prescriber believes it is necessary for a longer duration and documents the clinical rationale and duration."

Review of R49's "Face Sheet," located under the "Resident" tab of the electronic medical record (EMR), indicated R49 was admitted with diagnoses that included ventilator dependence and chronic kidney disease.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 758	Continued From page 64 Review of R49's "Physician Order," dated 12/13/22 and located under the "Resident" tab of the EMR, indicated R49 was to receive lorazepam, an anti-anxiety medication, 0.5 milligrams (mg) every eight hours as needed for anxiety through 03/12/23. This was for longer than 14 days after the order was written. Review of R49's "Progress Notes" and "Physician Progress Notes," dated 12/13/22 through 02/20/23 and located under the "Resident" tab of the EMR, revealed no documentation of the physician's rationale for the PRN anti-anxiety medication order to last longer than 14 days. During an interview on 02/23/23 at 11:15 AM, the Director of Nursing (DON) stated the facility's policy on the use of PRN anti-anxiety medications was that the order could not be for more than 14 days without a rationale documented by the physician. The DON confirmed there was no rationale documented to explain why R49 required the PRN medication longer than 14 days. During an interview on 02/23/23 at 12:30 PM, the Consultant Pharmacist stated it was the nursing staff's responsibility to ensure a rationale was documented related to an as need anti-anxiety medication order lasting longer than 14 days. The Consultant Pharmacist stated she did not look for a documented rationale for the PRN psychotropic medication to exceed 14 days. (Cross- reference F756 regarding identifying and acting upon irregularities.) 2. Review of R11's undated "Resident Face	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 758	Continued From page 65	F 758		

Sheet," located in the resident's EMR under the "Resident" tab revealed the resident was admitted to the facility on 11/01/17 with diagnoses of anxiety disorder and major depressive disorder.

Review of R11's "Prescription Order," dated 11/07/22, located in the resident's EMR under the "Orders" tab revealed the following orders dated 06/29/21 and 11/18/21, respectively: "Venlafaxine [antidepressant] 225 mg [milligrams]; Ativan (lorazepam - anti-anxiety medication] - 0.5 mg; amt [amount]: 1/2 tab [tablet]"

Review of R11's December 2022 - February 2023 "Medication Admin[stration Record," located in the resident's EMR under the "Resident" tab revealed the nursing staff administered the above-mentioned medication as ordered by the physician.

Review of R11's "Physician Recommendation," dated 10/19/21, located in the resident's EMR under the "Resident" tab revealed a gradual dose reduction (GDR) for Ativan was agreed upon by the physician on 10/29/21. Review of "Physician Recommendation," dated 11/29/21 revealed a GDR for Venlafaxine was agreed upon by the physician on 12/01/21. Review of R11's complete medical record showed no additional attempts at a GDR since 2021 or evidence of a clinical rationale documenting the reasoning further GDRs should not be attempted for R11's Venlafaxine or Ativan.

Review of R11's psychiatric notes for 10/07/22 revealed, "Moods is improving. Remains with depressed moods at times. Appetite decreased. Sleep good. Decreased anxious and irritable moods. Plan adjust medication." However, review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 758	Continued From page 66 of R11's complete medical record revealed no evidence of a medication adjustment. During an interview on 02/22/23 at 12:07 PM, the DON confirmed the facility did not have evidence of an attempted GDR since 2021 or a clinical rationale documenting the reasoning a GDR should not be attempted for R11's Venlafaxine or Ativan.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary 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, interview, record review, and review of facility policy, the facility failed to provide food storage in a safe and consistent manner. Frozen food was not stored at a temperature to ensure that the food remained	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 812	Continued From page 67	F 812		

frozen. Expired perishables were available for use. Opened foods were not securely closed, labeled, and dated. This had the potential to affect 45 of 62 residents who consumed food from the kitchen.

Findings include:

Review the of facility's undated policy titled, "Food Storage (Dry, Refrigerated, and Frozen)" indicated, "Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety." This policy also indicated, "General storage guidelines to be followed: a. All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded; c. Discard food that has passed the expiration date, and discard food that has been prepared in the facility after seven days of storing under proper refrigeration."

Review the of facility's undated policy titled, "Refrigerator and Freezer Temperatures" indicated, "2. The employee ensures that all cold storage units are 41"F [degrees Fahrenheit] or below for refrigeration or 0 "F or below for freezers." This policy further indicated, "3. The temperature of each refrigeration and freezer unit is checked by the staff member who is closing the department for the day. The temperature is verified to be in the correct range as listed in #2 above. If the unit is not in the correct operating range, the staff member alerts management per facility policy."

1. During an initial kitchen walkthrough with the Dietary Manager (DM) on 02/20/23 beginning at 9:00 AM, the following was observed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 812	Continued From page 68	F 812		

a. The ice machine had some black buildup on the right interior and on edge. The DM stated, "The ice machine is cleaned monthly by kitchen staff or as needed. A quarterly flushing/sanitation is completed by an outside company." The DM stated that she would clean the black substance right away.

b. In the stand-up meat freezer, immediately upon opening freezer, the temperature gauge read 10 degrees. The temperature affixed to the side of the stand-up meat freezer revealed the most recent temperature of -10 degrees on 02/20/23. The DM stated that Dietary Aide (DA) documented the freezer temps this morning. An interview was conducted with the DA at this time. The DA stated, "The temperature was 10 degrees, not -10 degrees. I put that number down by mistake." Further review of the temperature log showed the temperature was documented as above 0 degrees for 18 of 19 days in the month of February 2023, with one additional day not being documented. The DM stated she was unaware that there were any issues with the freezer. The DM further stated "The freezer temp should be 0 degrees and below. The staff should have informed me of the freezer issue."

c. In the stand-up meat freezer, there were 12 packs of Hillshire Farm smoked ham, 32-ounce packages, starting to thaw as evidenced by water droplets in the packages. The DM stated, "We are going to remove these immediately and figure out what is going on with the freezer."

d. In the dry storage room, there was a 16-ounce carton of corn starch, opened, undated, and unlabeled. The DM stated this item should be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 812	Continued From page 69 dated and labeled. e. In the dry storage room, there was a six-pound carton of rainbow sprinkles opened to air, undated and labeled. The DM stated, "I'm going to discard this." f. In the dry storage room, there was a 16-ounce bag of marshmallows, open to air, undated and unlabeled. The DM stated the food should not be opened to air and should also be dated labeled. g. In the dry storage room, there were four bags of coconut flakes with a date printed on each bag of 8/4/21 and a written date on each bag of 9/11/21. The DM stated "I am unsure of the dates but the items should be thrown out." h. In the walk-in cooler, there was a container of what the DM stated was icing. The icing was undated and unlabeled. The DM stated the item is required to be dated and labeled. i. In the walk-in cooler, there was a container with an onion and pepper, both cut in half, undated and unlabeled. The DM stated the items is required to be dated and labeled. j. Near the cook's area, there were two 25-pound containers of flour and sugar, undated and unlabeled. The DM stated the items should be dated and labeled. 2. During a tour of the refrigerators outside of the kitchen with the DM on 02/20/23 beginning at 9:37 AM, there were three eight-ounce cartons of milk with an expiration date of 02/17/23 in the refrigerator on the West unit. The DM stated,	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 812	Continued From page 70 "Staff gets all of the items from the kitchen and these should have been disposed of." During an interview on 02/20/23 at 9:45 AM, the DM stated she expected all foods to be stored properly, including being dated and labeled as required. The DM stated that she expected the staff to check as needed for expired foods. During an interview on 02/23/23 at 10:16 AM, the Administrator stated she expected the freezer to be in working order, food to be stored appropriately and expired foods to be discarded.	F 812		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 849	Continued From page 71 (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 849	Continued From page 72 (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 849	Continued From page 73	F 849		

interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 849	Continued From page 74 any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the appropriate coordination of hospice care by specifically failing to maintain hospice orders and/or hospice election forms for two (Resident (R) 6 and R19) of two residents sampled for hospice. This failure had the potential result in the interruption of the residents' coordination of care. Findings include: Review of the hospice agreement titled "Patient/Resident Services Agreement," dated 08/20/20, indicated " EveryStep will provide the following information to Contractor: The most recent hospice plan of care specific to each patient; Hospice election form and any advance directives specific to each patient; Physician certification and recertification of the terminal illness specific to each patient; Names and contact information for hospice personnel involved in hospice care of each patient;	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 849	Continued From page 75	F 849		

Instructions on how to access the hospice's 24-hour on-call system; Hospice medication information specific to each patient; and Hospice physician and attending physician orders specific to each patient."

1. Review of R6's undated "Resident Face Sheet," located in the resident's electronic medical record (EMR) under the "Resident" tab revealed the resident was admitted to the facility on 01/23/18.

Review of R6's "Resident Progress Notes," dated 01/11/23, located in the resident's EMR under the "Resident" tab revealed the resident was admitted to hospice on 01/11/23.

Review of R6's complete medical record, revealed the absence of hospice orders and a hospice election form.

During an interview on 02/21/23 at 9:38 AM, the Director of Nursing (DON) reviewed R6's EMR and hospice binder. The DON confirmed there were no hospice orders or a hospice election form for R6. When asked why the resident was on hospice, the DON stated, "because she had an overall decline in condition." The DON stated the hospice orders and hospice election form should be maintained at the facility.

During an interview on 02/21/23 at 10:13 AM, Hospice Registered Nurse (RN) stated R6 "started on hospice in January for her rapid decline with dementia." The Hospice RN confirmed the hospice order and hospice election form should be maintained on file at the facility. The Hospice RN stated, "That's just our normal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 849	Continued From page 76	F 849		

standard of practice. We provide the facility with that information plus the care plan when a resident is admitted to hospice."

2. Review of the facility's "Nursing Facility Hospice and Respite Care Services Agreement." dated 03/22/18, revealed in Part II, Section At2: "The Plan of Care will be established by the Attending Physician, the Medical Director, or physician-in-charge and the Interdisciplinary Team prior to the provision of hospice services and will be established and maintained in consultation with Facility's representatives. The Plan of Care will identify the care and services that are needed and will specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Plan of Care."

During the initial tour on 02/20/23 at 10:35 AM, R19 stated that she is receiving hospice services as of 01/26/23.

Review of R19's "Hospice and Coordinated Plan of Care," dated 01/26/23, revealed there were no times or dates for services performed. There were no sheets available to show the routine care interventions. Further review of the resident's record revealed no physician's orders for hospice services, and no evidence of coordination by the Hospice Nurse and the Facility Nurse.
During an interview on 02/2/123 at 11:35AM, the DON stated that the facility could not find the Hospice contact, care coordination notes or schedule for when services were to be provided. Further interview with the DON revealed it should be there.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 849	Continued From page 77 During an interview on 02/21/23 at 12:15 PM, the Administrator stated that the resident was transferred from the hospital with orders for hospice care. The Administrator confirmed that there were no physician's orders at the facility to continue hospice care, stating that because of the discharge summary for hospice care, there was no need for a doctor's order. Review of the "Hospice Agreement" between Southeast Iowa Regional Medical Center and Mississippi Valley Healthcare & Rehabilitation Center dated January 26, 2023, revealed in Appendix A "Hospice Admission Criteria" Section 1B: "The Attending Physician agrees to patient admission and is willing to remain actively involved in provision of medical care to the patient."	F 849		
F 880 SS=E	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. §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,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 880	Continued From page 78 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 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.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 880	Continued From page 79 §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 observation, interview, and record review, the facility failed to ensure staff performed hand hygiene during meal service so as to potentially prevent the development and transmission of communicable diseases for two of two dining observations in the main dining room. Findings include: During a continuous dining observation on 02/20/23 at 12:05 PM through 12:35 PM, the following was observed: 1. Certified Nursing Assistant (CNA)2, Dietary Aide (DA)5, Activity Assistant (AA), Dietary Manager (DM), DA3, and DA4 were observed serving meal trays to residents. These staff were observed to do the following: Remove meal trays from the steam table area. Serve the meal tray to the resident. Set up resident's meal, which included opening creamers, straws, setting up utensils, stirring in creamers. Adjust resident's chairs, wheelchairs, don clothing protectors, and adjust resident's clothing. Return to the steam table area to get another resident's tray and repeat the above steps. During this time, DA4 was also loading the cart for hallway meal trays.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 880	Continued From page 80 a. Throughout the meal process. CNA2, DA5, AA, DM, DA3, and DA4 failed to perform hand hygiene during the above process, as they passed trays and made contact with multiple residents. b. After passing meal trays, CNA2 was observed to begin feeding Resident (R) 31. CNA2 failed to perform hand hygiene between passing meal trays and assisting R31 with eating. c. DA5 was observed serving and setting up meal trays, pouring drinks, and going back and forth between the dining room and the kitchen, bringing resident food from the kitchen, and delivering to the resident. DA5 failed to perform hand hygiene during this observation. d. After passing meal trays, AA was observed to begin feed R27. AA was observed to put on gloves before she began assisting R27 to eat. AA was then observed to remove her gloves, open a condiment packet, and put the condiment on R27's food. AA then began cutting up food for R27's tablemate and went directly back to feeding R27. AA used the same silver to cut up the tablemate's food that the tablemate was already using. AA did not perform hand hygiene prior to feeding R27, after removing her gloves, or after touching the tablemate's silverware. During an interview on 02/20/23 at 12:35 PM, CNA2 stated she was taught to wash hands before serving meals in the dining room. During an interview on 02/20/23 at 12:36 PM, AA stated she taught to wash her hands "before serving meals and to wear gloves while feeding.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 880	Continued From page 81	F 880		

2. During a second continuous dining observation on 02/21/23 at 8:07 AM through 8:22 AM, the following was observed:
1. DA2, DA4, Restorative Licensed Practical Nurse (LPN)3, and CNA7 were observed serving meal trays to residents. These staff were observed to do the following:

Remove meal trays from the steam table area.
Serve the meal tray to the resident.
Set up resident's meal, which included opening creamers, straws, setting up utensils, stirring in creamers.
Adjust resident's chairs, wheelchairs, don clothing protectors, and adjust resident's clothing.
Return to the steam table area to get another resident's tray and repeat the above steps.
During this time, DA4 was also loading the cart for hallway meal trays.

Throughout the above process, DA2, DA4, Restorative LPN3, and CNA7 failed to perform hand hygiene as they touched multiple residents, as well as items such as silverware and glasses used by residents.

During an interview on 02/21/23 at 8:22 AM, DA2 stated she was trained to wash hands at the sink before serving meals.

During an interview on 02/21/23 at 8:23 AM, CNA7 stated, "I was trained to sanitize hands before meal pass and put on gloves when sitting to feed resident."

During an interview on 02/21/23 at 8:24 AM, DA4 stated he was trained to sanitize hands before

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSISSIPPI VALLEY	500 MESSENGER RD KEOKUK, IA 52632

(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 880	Continued From page 82 meals. During an interview on 02/23/23 at 10:16 AM, the Administrator stated, "I expect hands to be cleaned prior to walking into dining and between contact with residents. Also, after staff take their gloves off, they are supposed to wash their hands." During an interview on 02/23/23 at 10:40 AM, the Infection Preventionist (IP) stated, "Staff are to wash or sanitize hands before serving and after contact with residents. Staff are also to wash hands after removing gloves." During an interview on 02/23/23 at 10:48 AM, the DM stated, "I expect hand hygiene before coming to serve in the dining room and contact with residents. I also have told them not to wear gloves if they are not touching food because if they put gloves on and touch everything, the gloves are no longer clean. During an interview on 02/23/23 at 11:27 AM, the Director of Nursing (DON) stated, "I expect hands to be sanitized before feeding a resident. The staff should have gloves on also. Hands should be sanitized between contact with residents. I worry about that because we have so many residents with MDRO (multi-drug resistant organism) and don't want the organisms to spread."	F 880		

Mississippi Valley Healthcare and Rehabilitation
Recertification Survey and Complaints 2/20/2023-2/23/2023
Plan of Correction

Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and state laws. Without waiving the foregoing statement, the facility states as follows:

F550

All staff were educated on Resident Rights in regards to Dignity to include treating all residents in a respectful and dignified manner. Regarding Resident #25 and all other similarly situated residents, all staff were educated on the importance of being at eye level with a resident, maintaining face-to-face contact when assisting a resident to eat. Regarding Resident #21 and all other similarly situated residents' all staff were educated the importance of communicating resident needs for well fitted clothing and need for increased assistance with toileting/incontinence to ensure residents dignity is maintained. Smaller pants, biker shorts and suspenders were purchased for resident. Residents needs will be reviewed quarterly during care plan conferences and as needed by Director of Nursing and/or other designee as assigned. Director of Nursing and/or other designee as assigned will monitor for compliance on an ongoing basis.

Completion Date: 3/15/2023

F554
Regarding resident #11 and #37 both residents were assessed and found appropriate to self-administer nebulizer treatments. Both residents received education and return demonstrations were conducted to ensure competency and documented. Regarding resident #11, #37 and all other similarly situated residents, nurses were educated on importance of assessing a resident in conjunction with interdisciplinary team to determine whether self-administration of medications is safe and appropriate when a resident voices their wishes to self-administer medications. Director of Nursing and/or other designee as assigned will monitor for compliance on an ongoing basis.

Completion Date: 3/7/2023

F561
Dietary Manager met with resident #56 to discuss food choices as well as the nutritional supplement for wound healing. Regarding resident #56 and all other similarly situated residents, staff were educated regarding residents right to make choices about his/her aspect of life in the facility that are significant to the resident and importance of communicating the resident's expression of choice. The interdisciplinary team will review choices during care plan conferences and as needed. Director of Nursing and/or other designee as assigned will monitor for compliance on an ongoing basis.

Completion Date: 3/10/2023

F609

Administrator and all department heads have reviewed Federal Regulations to ensure appropriate understanding of reporting time frames for allegations of abuse. Administrator will ensure that reported allegation of abuse will be reported within a two-hour time frame. Administrator and/or Risk Manager will monitor for ongoing compliance.

Completion Date: 3/23/2023

F610

Administrator and all department heads have reviewed Federal Regulations regarding Investigative protocols. Administrator will ensure to obtain witness statements from all witnesses including alleged victims following an alleged report of abuse. Administrator and/or Risk Manager will monitor for ongoing compliance.

Completion Date: 3/23/2023

F623

Regarding resident #30, #32, #61, #116 and all other similarly situated residents a Transfer Notice/Bed Hold Notice was implemented and nursing staff educated. Form placed in transfer packets for nursing to include as part of transfer. Director of Nursing and/or other designee as assigned will monitor for compliance on an ongoing basis.

Completion Date: 3/25/2023

F637

Regarding resident #42 and all other similarly situated residents the MDS Coordinator was educated when to complete a significant change assessment when a major decline or improvement in the residents status that will not normally resolve itself without further investigation by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and review or revision of the care plan or both. Director of Nursing and/or other designee as assigned will monitor for ongoing compliance.

Completion Date: 2/24/2023

F641

Regarding resident #30, #42, #56, #21, and all other similarly situated residents the Social Service Director was educated on how to properly complete the MDS Section C. Residents that have the ability to communicate shall be interviewed to determine their cognitive and/or mood status and will not make their own determination in these areas. MDS Coordinator and Director of Nursing will monitor for ongoing compliance.

Completion Date: 2/24/2023

F656

Regarding resident #42 and all other similarly situated residents the Social Service Director was educated that the residents care plans shall address PASRR requirements for Level II PASRR residents, need for specialized services, crisis plan and interventions to assist resident in managing any behavioral symptoms, the episode of suicidal ideation requiring hospitalization, or previous attempts at self-harm. Resident #42 care plan has been updated to address the PASRR Level II requirements and behavioral concerns. MDS/Care Plan Coordinator, Social Service Director and Director of Nursing will monitor for ongoing compliance.

Completion Date: 3/24/2023

F657

Regarding residents #42, #56, #30 and all other similarly situated resident the MDS/Care Plan Coordinator was educated that the interdisciplinary team shall include a registered nurse with responsibility of the resident, nurse aide with responsibility of resident, member of nutrition services as well as other appropriate staff or professionals in disciplines as determined by resident's needs. MDS/Care Plan Coordinator and Director of Nursing will monitor for ongoing compliance.

Completion Date: 3/24/2023

F688

Regarding resident # 41 and all other similarly situated residents the Restorative nurse, restorative aides and nursing staff were educated on importance of ensuring residents who enter the facility without limited range of motion do not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. That a resident with limited range of motion receive appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Residents with limited mobility receive appropriate services, equipment and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Restorative aides were educated on splint programs and necessary documentation. Restorative Nurse is implementing orders onto MAR for application of resident splints by nursing when restorative nursing is not available. Restorative Nurse and Director of Nursing will monitor for ongoing compliance.

Completion Date: 3/31/2023

F740

Regarding resident #42 and all other similarly situated residents the Social Service Director was educated that the residents care plans shall address Behavioral Health services needed to attain or maintain the highest practicable physical, mental and psychosocial well-being. Resident #42 care plan has been updated to address the behavioral health needs to include PASRR Level II recommendations and crisis plan. Crisis Plan was made available to staff in Behavioral Crisis Plan binder at Nurses Station and nursing staff educated on Crisis Intervention Plans and location. Social Service Director and Director of Nursing will monitor for ongoing compliance.

Completion Date: 3/24/2023

F756

Regarding resident #11, #49 and all other similarly situated residents the Medication Review policy and regulations for Drug Regimen Review/Gradual Dose Reduction were reviewed with NuCara Pharmacy CEO and pharmacy consultant. Consultant pharmacist was educated and will conduct drug regimen reviews on each resident monthly to include gradual dose reductions for psychotropic medications every 6 months. When an as needed (PRN) anti-anxiety medications is noted to have order for longer than 14 days with no rationale and duration the pharmacist will alert the Director of Nursing. Director of Nursing and/or other designee as assigned will monitor for compliance on an ongoing basis.

Completion Date: 3/24/2023

F758

Regarding resident #11, #49 and all other similarly situated residents the Medication Review policy and regulations for Drug Regimen Review/Gradual Dose Reduction were reviewed with NuCara Pharmacy CEO and pharmacy consultant. Consultant pharmacist was educated and will conduct drug regimen reviews on each resident monthly to include gradual dose reductions for psychotropic medications every 6 months. Medical Director/primary physician was educated to include clinical rationale for as needed (PRN) anti-anxiety medications to continue longer than 14 days. Consultant pharmacist will review during monthly reviews and when an as needed (PRN) anti-anxiety medications is noted to have order for longer than 14 days with no rationale and duration the pharmacist will alert the Director of Nursing. Director of Nursing and/or other designee as assigned will monitor for compliance on an ongoing basis.

Compliance Date: 3/24/2023

F812

Temperature found to be out of range in the stand-up meat freezer. The Dietary Manager immediately removed frozen food and defrosted the freezer. Freezer has remained within normal temperature ranges since defrosting freezer. Dietary staff were educated on the steps to take when temperatures are out of range.

The ice machine was cleaned immediately upon discovery of black buildup by the Dietary Manager. Dietary staff were educated on the monthly cleaning schedule and instructions for ice machine cleaning were placed on the side of the ice machine as a reference.

The items open and undated in the walk-in cooler and dry storage were discarded immediately by Dietary Manager. Dietary Staff were educated on proper storage, labeling and discarding of undated foods.

Outdated milk found in the refrigerator on the West nursing unit was discarded. Dietary staff were educated to check the nursing unit refrigerators daily for outdates.

Dietary Manager and/or other designee as assigned will monitor for ongoing compliance.

Completion Date: 3/20/2023

F849

Regarding resident #6, #19 and other similarly situated residents the hospice order, hospice election form, hospice care plan and hospice coordination obtained immediately and placed into each resident's hospice binder. An admit to hospice order will be entered as a physician order by nursing when primary physician agrees to hospice services for a resident. Director of Nursing and/or other designee as assigned will monitor for compliance on an ongoing basis.

Completion Date: 3/24/2023

F880

All staff were re-educated on hand hygiene policy and hand hygiene during meal service. All staff viewed the CDC videos on Clean Hands and Sparkling Surfaces. Infection Preventionist is in contact with Gina Anderson at Telligen for assistance in completing training and conducting a Root Cause Analysis. Infection Preventionist and/or other designee as assigned will continue to monitor compliance on an ongoing basis through periodic audits and observation.

Completion Date: 3/30/2023