Citation Numb	per:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024		
Reola, Iowa 32246					
Rule or Code Nature of Vic Section		e of Violation	Class	Fine Amount	Correction date

58.19(2)j	481—58.19(135C) Required nursing services for	CLASS I	\$8,500.00	UPON
	residents. The resident shall receive and the facility		HELD IN	RECEIPT
	shall provide, as appropriate, the following required		SUSPENSION	
	nursing services under the 24-hour direction of			
	qualified nurses with ancillary coverage as set forth in			
	these rules:			
	58.19(2) Medication and treatment.			
	j. Provision of accurate assessment and timely			
	intervention for all residents who have an onset of			
	adverse symptoms which represent a change in			
	mental, emotional, or physical condition. (I, II, III).			
	DESCRIPTION:			
	Based on observation, interview, clinical record			
	review, and facility policy review, the facility failed to			
	provide adequate assessment and intervention for 3			
	of 4 residents reviewed for a change in condition. On			
	9/07/24 at approximately 12:30 PM, Resident #25 had			
	difficulty transferring, which was a significant change			
	in status, then at 2:35 PM the resident later had an			
	unwitnessed fall, and was found face down in another			
	resident's room, with laceration to the left forehead,			
	Physician was sent a fax on 9/07/24, however, there			
	was no response from physician until 9/09/2024			
	which noted they should could continue to monitor			
	per facility protocol. There was no follow-up from the			

Page 1 of 97

Facility Administrator

Date

Citation Numb	er:				Date: December 10, 2024 Amended 2/20/25	
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024			
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР				
Neola, Iowa 52240						
Rule or Code Nature of Violation Section		Class	Fine Amount	Correction date		

facility between 9/07/2024 and 9/09/2024. Staff		
acknowledged continued decline in Resident #25's		
condition when Resident #25 required assistance and		
cueing with all meals when independent prior. The		
Resident declined to a non-weightbearing of the left		
leg. The physician was notified on 9/17/24 of decline		
in transferring, at which time x-ray of a hip performed,		
no diagnostic tests were completed at this time for		
the head injury, there was no fracture of the hip. On		
9/22/24 Resident #25 transferred to the Hospital, due		
to experiencing stroke-like symptoms and was		
diagnosed with Subdural Hematoma. Resident #25		
died on 9/29/24. Resident #25's death certificate		
revealed the immediate cause of death as		
complications due to accidental elderly fall, Due to or		
as a consequence of: subdural hematoma, and due to		
or as a consequence of an unsteady gait. The facility		
additionally failed to complete neurological		
assessments and post fall follow up documentation		
for Resident #20 following an unwitnessed fall and		
further failed to provide continued assessment for		
Resident #226 after an episode of excessive coughing		
caused by consuming the incorrect consistency of		
food during lunch meal for a resident with dysphagia.		
The facility reported a census of 26 residents.		
Findings include:		
		Daga 2 of 0

Page 2 of 97

Facility Administrator

Date

Citation Numb	per:				ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024			
	-2-70					
Rule or Code Nature of Violation Section		Class	Fine Amount	Correction date		

1. The Admission Minimum Data Set (MDS), dated		
6/19/24, revealed Resident #25 had severely impaired		
cognitive skills for daily decision making and		
occasional behaviors that included wandering and		
rejection of cares. Resident #25 had no impairment of		
the upper or lower extremities and did not require		
use of mobility devices. The Admission MDS revealed		
that Resident #25 was able to ambulate at least 150		
feet independently, transfer independently, and eat		
independently after set up assistance. Resident #25		
had history of a fall in the last 2-6 months prior to		
facility admission and utilized a wander/elopement		
alarm on a daily basis. Diagnoses included Alzheimer's		
Disease and osteoporosis.		
A Significant Change MDS, dated 9/19/24, revealed		
Resident #25 received Hospice Care services, while a		
resident at facility, and had one fall with non-major		
injury since admission (major injury defined in MDS as		
fall resulting in bone fracture, joint dislocation, closed		
head injury with altered level of consciousness, or		
subdural hematoma). The Significant Change MDS		
revealed that Resident #25 required use of walker and		
wheelchair for mobility with substantial to maximal staff assistance to ambulate at least 10 feet and		
dependent on staff to transfer. Resident #25 required		
supervision or touching assistance with eating and		Page 3 of s

Facility Administrator

Date

Citation Numb	er:				Date: December 10, 2024 Amended 2/20/25	
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024			
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР				
Neola, Iowa 52240						
Rule or Code Nature of Violation Section		Class	Fine Amount	Correction date		

substantial to maximal staff assistance with hygiene and dressing tasks. Diagnoses included: Non-traumatic brain dysfunction, Alzheimer's Disease, and osteoporosis.		
The Care Plan, initiated 6/14/24, identified Resident #25 at risk for falls and injury due to wandering and decreased safety awareness. The Care Plan revealed Resident #25 had an unwitnessed fall on 9/07/24 with a bruise to hip, interventions included a urine dip and an evaluation to be completed by Physical/Occupational Therapy. Fall risk interventions listed in the Care Plan instructed staff to: anticipate the resident's needs, ensure resident wore appropriate footwear when ambulating, provide safe environment with floor free of spills or clutter, adequate light, call light in reach, bed in low position at night, side rails as ordered, handrails on walls, and personal items within reach.		
On 9/07/24 at 3:26 PM, Nursing Progress Note revealed a yell had been heard down East Hall at 2:35 PM, Resident #25 observed face down on the floor in another resident's room. The Progress Note informed that Resident #25 had been known to wander, was last seen in lobby area, last toileted around 1:15 PM, and wore grippy socks. Progress Note revealed that active range of motion was intact and that Resident		

Page 4 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 led 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024		
Rule or Code Section	Code Nature of Violation		Class	Fine Amount	Correction date

#25 was assisted by one staff to a standing position, then walked down the hall until a staff arrived with wheelchair when Resident #25 still appeared to be unsteady. Resident #25 noted to have sustained a skin tear to the left forehead, measuring 2 centimeters (cm) long by 0.5 cm wide, and required skin to be approximated (closed) using 3 steri strips (adhesive skin closures). Nursing documented Resident #25's Power of Attorney (POA) was notified of fall and that the Provider had been faxed with results of a urine dip		
performed and Resident #25's injuries. A facility facsimile (fax), dated 9/07/24, revealed an FYI notification sent to Provider which informed that Resident #25 observed prone on the floor in another resident's room and had skin tear to the left forehead with steri strips in place. Fax revealed that nursing would monitor every shift for 3 days, then weekly for 3 weeks and included results of a urine dip performed related to POA's indication of past falls with Urinary Tract Infection (UTI). Provider response to fax, dated 9/09/24, instructed nursing to monitor per facility protocol and to obtain a Urinalysis with culture and sensitivity if indicated.		
On 9/08/24 at 10:08 AM, Nursing Progress Note revealed Resident #25 continued on post fall monitoring and had utilized a wheelchair due to an		

Page 5 of 97

Facility Administrator

Citation Numb	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР			
Reola, 10wa 52240					
Rule or Code Section	Code Nature of Violation		Class	Fine Amount	Correction date

unsteady, weak gait. Progress Note informed that facility was awaiting response from Provider regarding Resident #25's urine dip.		
Review of Resident #25 Electronic Health Records (EHR), revealed a neurological assessment had been completed on the following dates and times: 9/07/24 at 2:35 PM, 9/07/24 at 6:35 PM, 9/07/24 at 10:35 PM, 9/08/24 at 2:54 AM, 9/08/24 at 6:35 AM, 9/08/24 at 2:25 PM, 9/08/24 at 10:35 PM, and 9/09/24 at 7:59 AM. Neurological assessments included normal findings of vital signs, orientation to person/place/time, level of consciousness, pupil size, ability to respond appropriately, pain, and movement of extremities.		
The facility provided two additional hand-written neurological assessments, both dated 9/09/24, and both lacked documentation of the time completed. One hand written neurological assessment informed that Certified Nursing Assistant (CNA) reported difficulty with lower extremity movement when ambulating Resident #25 to the toilet. The second hand written neurological assessment informed that Resident #25 had 3 steri strip closures to left forehead, a large purple bruise to the left hip, and bruising to 2 digits on the left hand.		

Page 6 of 97

Facility Administrator

Date

Citation Number: #10682					ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024		
Neola, Iowa 52240					
Rule or Code Nature of Violation Section		Class	Fine Amount	Correction date	

 				_
The facility provided two pages of hand-written				
Nursing Progress Note. Review of note dated 9/09/24				
at 1:00 PM, revealed a fax had been received related				
to fall with an order to obtain Urinalysis (UA) with				
culture and sensitivity. Progress Note also revealed				
that Resident #25 was unable to stand on her own,				
leaning to the left when walking, utilizing a				
wheelchair, and had large bruises noted on left outer				
hip. Review of a hand-written Nursing Progress Note,				
dated 9/09/24 at 6:30 PM, revealed Resident #25				
ambulated with staff assist of one, was noted to favor				
the left side, and stumble during ambulation.				
, G				
A Provider Visit Note, dated 9/11/24, revealed				
Resident #25 had fallen on 9/07/24 with skin tear to				
head and stable neuros. Provider documented that				
review of systems taken with assistance from nursing				
staff and chart review due to Resident #25 poor				
cognition, with no concerns or acute issues per				
nursing staff. Provider listed the following under				
orders and requisitions: monitor unsteadiness and				
weakness, complete neuro checks per protocol,				
complete skin checks per protocol, and continue				
current medications and treatment.				
On 9/17/24 at 1:07 PM, a Nursing Progress Note				
revealed that Resident #25 had not been bearing				
weight on left leg after fall and a fax was sent to the				
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Page 7 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 led 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024		
Neola, Iowa 52240					
Rule or Code Nature of Violation Section		Class	Fine Amount	Correction date	

physician about a possible x-ray. On 9/17/24 at 8:40 PM Provider ordered x-ray to include 2 views of pelvis and left hip for acute pain post fall and to monitor bruise until healed. On 9/18/24 at 1:23 PM, a portable x-ray performed on Resident #25 left hip, results were negative for fracture.		
Review of Resident #25's Electronic Health Records and paper clinical records, revealed no Provider notification related to change in transfer ability or notification of left hip bruising was documented between the dates of 9/07/24 and 9/17/24.		
A Change in Condition Assessment completed on 9/18/24, revealed Resident #25 had recent fall with a decline in mobility, utilized a wheelchair, and required total staff assistance with transfers, mobility, and hygiene. Change in Condition Assessment informed that Resident #25 was unable to bear at least 50% weight on at least 1 leg and unable to sit upright without physical assistance.		
A Care Conference Note, dated 9/19/24, revealed that prior to fall, Resident #25 was often found walking around and sitting in staff offices to visit with staff and other residents. At time of Care Conference, Resident #25 required increased assistance in activities of daily living and feeding assistance post fall.		

Page 8 of 97

Facility Administrator

Date

Citation Numb	er:			Date: December 10, 2024 Amended 2/20/25		
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,	
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР				
Neola, Iowa 52240						
Rule or Code Nature of Violation Section		Class	Fine Amount	Correction date		

Review of a facility fax, dated 9/19/24, revealed notification to Provider the following information: Physical Therapy (PT) to evaluate, Resident #25 not walked since fall 2 weeks ago. Fax included results of x-ray completed 9/18/24 of left pelvis/hip. Provider response received 9/19/24 with order for PT to evaluate and treat.		
On 9/21/24 at 6:04 PM, Nursing Progress Note revealed that Resident #25 continued to have a decline, sat at resident assisted feeding tables but did not eat, and was noted to be lethargic. Note informed that POA was notified, no documentation of Provider notification for decline in condition.		
On 9/22/24 at 10:37 AM, Nursing Progress Note revealed that nurse spoke to on-call Provider at 8:45 AM and received order to send Resident #25 to the Emergency Room for evaluation to rule out stroke. Resident #25 noted to continue with lethargy and decrease in level of consciousness. Resident #25 transferred from facility to hospital via ambulance at 9:40 AM.		
Hospital Discharge Report, dated 9/22/24, revealed that Resident #25 had a large subdural hematoma and likely the cause for decline in mental status and		

Page 9 of 97

Facility Administrator

Date

Citation Numb	er:				Date: December 10, 2024 Amended 2/20/25	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР	2024	2024		
Keota, Iowa 52248						
Rule or Code Nature of Violation Section		Class	Fine Amount	Correction date		

functional abilities. Diagnoses listed as Altered Mental Status and Subdural Hematoma.
On 9/22/24 at 1:19 PM, Nursing Progress Note revealed Resident #25 returned to the facility via
ambulance with diagnosis of subdural hematoma.
Note indicated POA requested Resident #25 be
admitted to Hospice. On 9/22/24 at 1:26 PM, verbal orders received from Provider for referral to Hospice
services and to discontinue Physical/Occupational
Therapy orders.
Review of Provider Visit Note, dated 9/25/24,
informed that Resident #25 had unwitnessed fall, was
admitted to the hospital, and found to have a subdural hematoma. Provider documented that
Resident #25 had a significant decline in her status,
was weak, lethargic, and slow to respond. Visit Note revealed that Resident #25 had been admitted to
Hospice.
On 0/20/24 at 0:45 ANA Resident #25 deceased
On 9/29/24 at 9:45 AM, Resident #25 deceased. Hospice and family present at the facility. Note
informed that Hospice had contacted the Medical
Examiner.
Resident #25 Certificate of Death, revealed immediate
cause of death from complications due to accidental

Page 10 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 led 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР			
Keota, Iowa 52248					
Rule or Code Section	Nature of Violation		Class	Fine Amount	Correction date

	elderly fall, due to or as a consequence of subdural		
	hematoma, due to or as a consequence of unsteady		
	gait and dementia. Manner of Resident #25's death is		
	listed as an accident with the date and time of injury		
	occurring on 9/07/24 at 2:35 PM at the facility. A		
	description of injury informed that on 9/07/24 at 2:35		
	PM, facility heard a yell and nurse found Resident #25		
	laying prone, face down on the floor of another		
	residents' room, sustained a skin tear on the left side		
	of the forehead and that resident did not bear weight		
	on her left leg.		
	On 11/06/24 at 11:00 AM, Staff B, Licensed Practical		
	Nurse (LPN) revealed that Resident #25 wandered		
	independently throughout the facility prior to fall and		
	that around the same time of fall, she never walked		
	again. Staff B recalled coming back to work after a		
	weekend and finding that Resident #25 had steri strips		
	on her head and a dark bruise on left hip after a fall.		
	Staff B did not recall speaking with the Provider about		
	Resident #25's decline in transfer ability. Staff B		
	informed that facility protocol for completing		
	neurological assessments was to assess residents		
	every 4 hours, then every 8 hours for 3 days.		
	On 11/06/24 at 2:40 PM, Staff D, Licensed Practical		
	Nurse (LPN), revealed that Resident #25 had difficulty		
	transferring and ambulating, and required use of a		
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Page 11 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 led 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР			
Keota, Iowa 52248					
Rule or Code Section	Nature of Violation		Class	Fine Amount	Correction date

wheelchair, on the morning of her fall. Staff D stated		
that she had been called to Resident #25's bathroom,		
sometime shortly after lunch, by Staff N, Certified		
Nursing Assistant (CNA) due to residents struggling to		
get up from the toilet. Staff D stated that she helped		
CNA get Resident #25 up from toilet and recalled that		
Resident #25 had struggled to get up from the toilet		
but was able to ambulate once up. Staff D informed		
that she did not put Resident #25 back in a wheelchair		
because she normally ambulated independently. Staff		
D stated that about 3 hours after helping to assist		
Resident #25 up from the toilet, a fall occurred. Staff		
D reported that another resident came out of their		
room and told nurse that Resident #25 fell. When		
Staff D approached the other resident's room, she		
recalled that Resident #25 had been laying face down		
on the floor. Staff D stated that Resident #25 had skin		
tear to forehead with flaps of skin hanging down. Staff		
D recalled, Resident #25 had been able to move all		
extremities, was assisted to sit up on the floor, then		
assisted to a standing position and ambulated out of		
the room and into the hallway. When ambulating in		
the hallway, Staff D said Resident #25 had been a bit		
wobbly so another staff member got the wheelchair.		
Staff D stated Resident #25 sat in a wheelchair the		
rest of the day. Staff D stated Provider had been		
notified of fall with skin tear to head on 9/07/24 via		
fax and explained that on weekends the Provider		

Page 12 of 97

Facility Administrator

Date

Citation Numb	er:	Date: December ² Amended 2			ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР	- 2024		
Keota, Iowa 52248					
Rule or Code Natur Section		re of Violation	Class	Fine Amount	Correction date

would be faxed unless a resident needed to be sent out.		
On 11/07/24 at 2:50 PM Staff N, CNA, stated Resident #25 was in a wheelchair prior to falling due to weakness, attempted to get up from the wheelchair but couldn't. Staff N recalled reporting to nurse that Resident #25 was unstable in the bathroom from the toilet. Staff N stated it was unlike Resident #25 to need help getting up from the toilet, normally transferred and ambulated independently.		
On 11/07/24 at 11:58 AM, Director of Nursing (DON) confirmed that Resident #25 ambulated independently without use of an assistive device and wandered with steady gait prior to fall. DON recalled Resident #25 had been declining and was sent to the hospital for stroke-like symptoms. DON confirmed that a fax was sent to Provider to notify of fall with head injury and revealed an expectation that nurses call Provider for a fall with head injury. DON stated Resident #25 should have been sent to the Emergency Room (ER) the first day because of head injury. DON unable to provide documentation of additional communication with the Provider related to Resident #25 decline in mobility or condition change.		

Page 13 of 97

Facility Administrator

Date

Citation Numb	er:	Date: December 10, Amended 2/20			
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР	2024		
Keota, Iowa 52248					
Rule or Code Nature of Violation Section		e of Violation	Class	Fine Amount	Correction date

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On 11/19/24 at 12:30 PM, DON for sister facility,			
assisted facility during State Survey, revealed the			
expectation for post fall monitoring to include			
documentation at least every shift for 3 days and, in			
addition, nursing staff would need to complete			
neurological checks every 15 minutes x4, then every			
hour x4, then every 2 hours x4, then every 4 hours x4,			
then every shift for a total of 3 days. The sister facility			
DON revealed the expectation of nurses to call, not			
fax, a Provider immediately when a resident has any			
condition change and expected if a head injury is			
known for staff to call Provider and send residents to			
ER to evaluate.			
The facility policy titled, Change in a Resident's			
Condition or Status, dated 12/16/21, revealed that			
the nurse will notify resident's Attending Physician or			
physician on call when there has been a significant			
change in the resident's physical, emotional, or			
mental condition and informed that notifications will			
be made within 24 hours of change, except in medical			
emergencies. The policy defined significant change of			
condition as a major decline or improvement in a			
resident's status that:			
a. Will not normally resolve itself without intervention			
by staff or by implementing standard disease related			
clinical interventions.			

Page 14 of 97

Facility Administrator

Date

Citation Number: #10682 Facility Name:			Survey	Am	cemb	er 10, 2024 ed 2/20/25
Keota Health				oer 4, 2024 –	Nove	ember 19,
	ess/City/State/Zip (Washington Rd 2248	СР	- 2024			
Rule or						Correction
Code Section	Natu	re of Violation	Class	Fine Amou	unt	date
			1	1		
	 b. Impacts more than one area of the resident's health status. c. Requires interdisciplinary review and/or revision to the Care Plan. d. Ultimately is based on the judgement of the clinical staff. 					
	10/09/24, revealed Re for Mental Status (BIN indicated moderate co #20 utilized a wheelch substantial to maxima transfer. The MDS reve fall without injury sinc Diagnoses included no	The Quarterly Minimum Data Set (MDS), dated 0/09/24, revealed Resident #20 had a Brief Interview r Mental Status (BIMS) score of 8 out of 15, which dicated moderate cognitive impairment. Resident 20 utilized a wheelchair for mobility and required abstantial to maximal amount of staff assistance to ansfer. The MDS revealed that Resident #20 had one II without injury since the previous assessment. agnoses included non-traumatic brain dysfunction, on-Alzheimer's dementia, heart failure, and sychotic disorder.				

Page 15 of 97

Facility Administrator

Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

The Care Plan, revised 8/27/24, revealed Resident #20

at risk for injury from falls related to impaired mobility, bilateral macular degeneration, lumbar stenosis, Congestive Heart Failure, Peripheral Vascular Disease, dementia with mood disturbance, delusional disorder, and osteoarthritis of right knee. The Care Plan informed that Resident #20 had an unwitnessed fall without injury on 8/27/24. Fall intervention

Citation Numb	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР	- 2024		
Keota, Iowa 52248					
Rule or Code Nature o Section		e of Violation	Class	Fine Amount	Correction date

		1	
instructed staff to keep bed at appropriate height in order for the resident to stand safely.			
A Nursing Progress Note, dated 8/27/24 at 9:12 AM, revealed Resident #20 was found on the floor in the room and indicated that the resident had slid out of bed onto the floor. Note informed that neurological assessments would be completed per facility protocol and that notification of fall was provided to physician, family, Director of Nursing (DON), and Facility Administrator.			
On 8/27/24 at 6:47 PM, a Nursing Note informed that no injuries had been observed post fall, Resident #20 able to ambulate and transfer per baseline.			
On 8/28/24 at 10:14 AM, Nursing Note informed that neurological checks were within normal limits and Resident #20 had no complaints of pain. No additional documentation provided in Nursing Progress Notes related to fall on 8/27/24.			
Review of Resident #20's Electronic Health Records (EHR) revealed 2 neurological assessments had been completed on 8/27/24, at 3:46 PM and 9:57 PM, related to unwitnessed fall on 8/27/24.			

Page 16 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР	2024			
Keota, Iowa 52248						
Rule or Code Natu Section		ure of Violation	Class	Fine Amount	Correction date	

On 11/19/24 at 12:30 PM, Director of Nursing (DON) from sister facility, assisted with State Survey, revealed an expectation for post fall monitoring to include documentation at least every shift for 3 days and in addition nursing staff would need to complete neurological checks every 15 minutes x4, then every hour x4, then every 2 hours x4, then every 4 hours x4, then every shift for a total of 3 days		
The facility policy titled, Fall Management System, dated 9/2022, revealed expectation for resident evaluation to include the following: 1. Any fall that involves an actual head injury and all un-witnessed falls will include follow-up neurological checks. Neurological checks will be documented. 2. When a resident sustains a fall, an evaluation may include investigation to determine probable causal factors considering environmental factors, resident medical condition, resident behavioral manifestations, and medical or assistive devices that may be implicated in the fall. The investigation and appropriate interventions will be evaluated at the time of the fall and reviewed by Nursing Management or the IDT. Interventions secondary to the investigation will be documented in the Care Plan, as indicated.		

Page 17 of 97

Facility Administrator

Date

Citation Numb #10682	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР			
Keota, Iowa 52248					
Rule or Code Nature Section		e of Violation	Class	Fine Amount	Correction date

The facility policy titled, Neurological Evaluation, dated 7/20/19, revealed a Neurological evaluation may be indicated following an unwitnessed fall and instructed staff to complete evaluation every 15 minutes for an hour, then every 30 minutes for 4 hours, then every 1 hour for 2 hours, then every shift for 72 hours unless otherwise specified by physician order. Policy revealed expectation for documentation of neurological evaluations to include date and time procedure was performed, all assessment data obtained during procedure, if resident refused the procedure, and the signature and title of person recording the data.		
 3. The Medical Diagnosis form in Resident #226's Electronic Health Record had the following diagnoses listed: dysphagia (difficulty swallowing), gastro-esophageal reflux disease (acid irritates the throat), and mild cognitive impairment (difficulty processing thoughts). Resident#226's diet texture was ordered pureed texture with thin liquids. The Dysphagia Facility Policy, dated September 2017, directed staff to identify the cause of the dysphagia and obtain symptom details for proper treatment. 		
		Dogo 19 of

Page 18 of 97

Facility Administrator

Date

Citation Numb	per:				ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР		- 2024		
,						
Rule or Code Nature Section		ure of Violation	Class	Fine Amount	Correction date	

	Care Plan, initiated on 10/31/24, instructed staff erve diet as ordered.
Resi One that pro- afte time with	11/04/24 at 11:20 a.m., Staff A, Cook served ident #226 a plate of regular consistency food. e minute later, Staff A, Cook came back and stated the knew he was going to screw that up and ceeded to take the food away from Resident #226 r he had consumed several bites of food. At that e the resident had begun excessively coughing in a large amount of phlegm coming from mouth nose.
	11/04/24 at 11:22 a.m., Resident #226 stopped ghing and drooling.
the eati	11/04/24 at 11:24 a.m., Resident #226 was served correct consistency and proceeded to cough with ng intermittently, but was able to eat some more d of the pureed consistency.
on v stat han kitc the	11/04/24 at 11:30 a.m., the DON was interviewed what Resident#226's diet is ordered as and she ed that it is puree texture with thin liquids and dle cups. She stated that she provided it to the hen herself prior to the resident's arrival. She was n queried on what would happen if Resident #226 ald be provided with regular consistency food and

Page 19 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР			
Rule or Code Section	Code Nature of Violation		Class	Fine Amount	Correction date

she stated that he would most likely choke because he eats his food very fast. At this point in time, the State Agency (SA) notified the DON of the findings to allow for appropriate assessment and interventions for this resident.		
On 11/04/24 at 11:38 a.m., an interview from Staff A, Cook, revealed that the dietary staff get the dietary information from the nurses. Staff A, Cook, acknowledged that he provided the resident with regular consistency food and then noticed that his count was off for plates so he and went back to fix it. Staff A, Cook, acknowledged that Resident #226 would probably choke if he ate regular consistency food. When queried about the location of the modified diet postings in the kitchen, Staff A, stated that it is posted in the kitchen and that it is also in a book. Staff A, stated that he does not utilize the books because he has struggled with them.		
On 11/04/24 at 11:48 a.m., Resident #226 was found lying in his room alone. The Resident stated that he was fine and he did not feel short of breath. At that time, the resident was noted to still have an intermittent cough. The resident denied feeling like there was anything stuck in his throat.		

Page 20 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248			Dates: per 4, 2024 – Nov	2024 – November 19,	
		СР	2024		
	.240				
Rule or Code Section	Code Nature of Violation		Class	Fine Amount	Correction date

	1	-	
On 11/04/24 at 12:14 p.m., a second interview with the DON revealed that the resident had not yet had vitals or had an assessment and the physician had not been aware of the resident receiving the wrong consistency of food. The DON stated that she had a text out to the physician but had not talked with him yet. The DON reported that she had not yet done			
assessment or vitals due to behavioral issues with this resident.			
Observation on 11/04/24 at 12:47 p.m., revealed Resident #226 was observed lying in bed with a blanket covering him, and a nurse walked out of the room at that time.			
On 11/04/24 at 12:50 p.m., interview with Staff B, LPN revealed that she had assessed Resident #226 at approximately 12:30 p.m. and that vitals and lung sounds did not reveal anything out of the ordinary to her. When asked for the vitals, she stated that she had provided them to the DON for her to document.			
481—58.28(135C) Safety. The licensee of a nursing facility shall be responsible for the provision and			

Page 21 of 97

Facility Administrator

Date

Citation Number: #10682 Facility Name: Keota Health Care Center			Survey Novem	Ame	ember 10, 2024 Inded 2/20/25
	ess/City/State/Zip Washington Rd 2248	СР	2024		
Rule or Code Section	Natur	e of Violation	Class	Fine Amour	Correction at date
58.28(3)e	 maintenance of a safe environment for residents and personnel. (III) S8.28(3) Resident safety e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III) DESCRIPTION: Based on observation, interview, and record review the facility failed to ensure evaluation of a mobility device prior to resident use, failed to ensure gait belt utilized for transfer, failed to remain with a resident when a non-verbal resident suspected to have a seizure resulting in a fall, failed to ensure adequate supervision for resident with known history of falls when the resident was found multiple times post unwitnessed fall in the lobby of the facility, failed to ensure residents remained free from environmental hazards when one resident ingested a robin egg and another resident obtained access to a locked restroom without the knowledge of facility staff for six of ten residents reviewed for accidents 		CLASS I	\$7,500.00 HELD IN SUSPENSION	UPON RECEIPT

Page 22 of 97

Facility Administrator

Date

Citation Number: #10682					ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		No		Survey Dates: November 4, 2024 – November 19, 2024		
		СР	2024			
Rule or Code Section	Nat	ure of Violation	Class	Fine Amount	Correction date	

Resident #21, and Resident #22). This deficient		
practice resulted in the following injuries: Resident #2		
sustained bruises and a head laceration on 6/22/24.		
Resident #22 sustained a laceration to the right orbit		
with surrounding bruising, pain, and multiple skin		
tears sustained from falls on 7/5/24, 8/22/24, and		
9/3/24. Resident #5 sustained bruising to the right		
forehead, pain, and a shattered humerus related to a		
fall on 11/1/24 and was hospitalized.		
Findings include:		
1. Review of the Annual Minimum Data Set (MDS)		
assessment for Resident #5 dated 9/18/24 revealed		
the resident scored 00 out of 15 on a Brief Interview		
for Mental Status (BIMS) exam, which indicated		
severely impaired cognition.		
a. Review of Resident #5's Care Plan dated 4/2/21,		
revised 11/1/24, revealed the following: [Resident #5]		
is at risk for injury from falls r/t (related to) hx		
(history) of right (R) femur fx (fracture), dementia,		
diabetes, anemia, neurogenic bladder, muscle		
atrophy, hx of TIA/CVA (Transient ischemic		
attack/Cerebrovascular accident). Falls: 11/1/24		
witnessed fall with injury.		

Page 23 of 97

Facility Administrator

Date

Citation Numb	er:	Date: December 1 Amended 2/		•	
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР			
Reola, Iowa 32246					
Rule or Code Section	Code Nature of Violation		Class	Fine Amount	Correction date

Interventions per the Care Plan included the		
following:		
a. (Initiated 2/15/24, revised 9/10/24): Gripper strips		
to bed.		
b. (Initiated 2/15/24, revised 9/10/24): Gripper strip		
toilet.		
c. (Imitated 11/1/24): Send to ER (emergency room)		
for evaluation		
d. (Initiated 2/15/24, revised 9/10/24): Toilet rails		
Review of the Therapy Communication Form dated		
1/26/24 revealed, in part, pt. (patient) is functional		
independent with 4 ww (wheeled walker) gait in		
hallway & common spaces after assist with stance		
WBAT (weight bearing as tolerated).		
Review of the Late Entry Nursing Note dated 10/30/24		
at 11:00 AM revealed, Maintenance gave a		
three-wheel walker to the resident after being		
notified by Maintenance manager that this is the only		
walker that he has available at this time. Walker was		
given to the resident by the maintenance manager.		
Maintenance Manager had been notified of wheels		
loose on the resident's normal four-wheel walker and		
needing it to be fixed or replaced.		
Review of the Fall Incident Report dated 11/1/24 at		
7:38 AM for Resident #5 revealed, Nurse made aware		

Page 24 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 led 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – Novembe 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	- 2024		
Rule or Code Section	Code Nature of Violation		Class	Fine Amount	Correction date

of witnessed fall at 0738 from housekeeping down	
West hall way. Resd (resident) utilizing new 3ww	
(wheeled walker) et was turning around when she lost	
her footing. Resd Observed lying on rt side, head	
against wall, sensation et movement to extremities,	
able to move rt hand when asked, unable to assess	
AROM (active range of motion) to rt (right) arm at this	
time as she was lying on it. Resd x1 (times one)	
assisted to chair in activity room, utilized walker with	
rt (right) hand, gripping activity director shirt with It	
(left). 3x3cm (centimeter) bruise noted to rt (right)	
foreheadWhen skin protectant sleeve on rt arm	
rolled back up from obtaining BP (blood pressure)	
resd called out in pain. Swelling noted to rt arm et	
resd does not move extremity when asked. Verbal	
order to send to ER obtained at 0755 from [Name	
Redacted] fax out for signatureAmbulance arrived at	
0835 (8:35 AM), paramedic notes crepitus to rt arm,	
when requested to transport to [Location Redacted]	
medics refuse as hey state "We're not sure if its	
broken so we will start with x-ray in [Location	
Redacted]." [Resident #5] left facility via ambulance at	
0841,	
MAR (Medication Administration Record)/TAR	
(Treatment Administration Record), IPOST (Iowa	
Physician Orders for Scope of Treatment), face sheet	
et hospital transfer form sent with.	

Page 25 of 97

Facility Administrator

Date

Citation Numb	per:				ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024			
	-2-70					
Rule or Code Nature of Violation Section		re of Violation	Class	Fine Amount	Correction date	

Г			
	Per the Incident Report dated 11/1/24, Resident #5		
	had a bruise to the top of the scalp and a pain score		
	of 6.		
	The Incident Note dated 11/1/2024 at 1:58 PM		
	revealed, [Name Redacted] ER (Emergency Room)		
	nurse from		
	[Location Redacted] called facility, informed this nurse		
	that [Resident #5's] "humorous <sic> is shattered."</sic>		
	[Resident #5] is to be transported to [Location		
	Redacted], et ER has already notified POA (Power of		
	Attorney).		
	Review of a Radiology Report of the resident's right		
	elbow completed on 11/1/24 at 9:45 AM, with reason		
	for process documented as bruising around elbow		
	and fall, revealed the following: Findings/Impression:		
	Comminuted fracture of the distal humerus with		
	separation of medial and lateral epicondyles. Note of		
	49 mm (millimeter) butterfly fragment. There is		
	foreshortening and posterior displacement of the		
	distal fracture fragments with respect of the proximal		
	humerus. There is dislocation of the humeral ulnar		
	joint.		
	•		
	Review of Hospital Records dated with admission date		
	11/1/24, and date of discharge $11/4/24$, revealed the		
	following admitting diagnoses: fall, hematoma over R		

Page 26 of 97

Facility Administrator

Date

Citation Number: #10682					ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248			Survey Dates: November 4, 2024 – November 19, 2024		
		СР			
Rule or Code Nature of Violation Section		ature of Violation	Class	Fine Amount	Correction date
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(right) frontal area, just above R eye, distal R humerus		
fracture, and slightly angulated/overlapping, and UTI		
(urinary tract infection).		
On 11/07/24 at 10:55 AM Staff F, Housekeeper		
queried regarding Resident #5. When queried if she		
was familiar with the resident, Staff F responded she		
was. When queried if she worked when the resident		
had fallen, Staff F explained here recently she was		
getting ready to mop the West hall, happened to turn,		
and [Resident] was losing balance when tried to turn		
her walker around. Staff F explained the resident's		
walker had gotten stuck when [Resident] was turning		
around and happened to lose balance. Staff F		
explained went to try to catch [Resident], and didn't		
get to her in time. Staff F queried where occurred,		
and responded between the activity door and West		
hall. Per Staff F, the resident had a walker with her,		
and walker was 3-wheel walker the resident had		
recently gotten. When queried if Staff F saw the		
resident fall, said yes. When queried what happened		
next, Staff F explained the resident had fallen and hit		
head on the wall, and landed on her right side. When		
queried about visible injuries, Staff F responded she		
did not notice any visible injuries. Staff F		
acknowledged there were no staff around that (Staff		
F) saw when the resident fell. Per Staff F, after the fall		
was a bruise on the resident's forehead. Staff F		

Page 27 of 97

Facility Administrator

Date

Citation Numb	er:	Date: December Amended 2			ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР			
Reola, Iowa 52240					
Rule or Code Nature of Violation Section		Class	Fine Amount	Correction date	

	explained the resident did not say anything when she		
	fell, and did not call out or anything like that.		
	On 11/7/24 at 11:50 AM, the Director of Nursing		
	(DON) explained there was not a PT/OT evaluation		
	done for Resident #5's 3 wheeled walker. The DON		
	explained for a new piece of equipment, usually from		
	maintenance. The DON explained that it is called maintenance because of the resident's walker wheel.		
	Per the DON, the resident was ordered to use a 4		
	wheeled walker, and DON explained called to have it		
	fixed and replaced with another 4 wheeled walker.		
	The DON further explained the facility was getting a		
	new admission at the time, maintenance came out		
	with a walker, was told it was the wrong walker,		
	maintenance said it was brand new, and DON said it		
	was the wrong walker. The DON explained she went		
	to the admission, staff had the resident sitting in a		
	chair, maintenance gave 3 wheeled walker, and		
	definitely should not have. The DON explained did not		
	know if there was another 4 wheeled walker or not,		
	and didn't have access to storage.		
	The DON explained if a witnessed fall, they would do		
	statements and had a fall report checklist. Per the		
	DON, statements were turned into the DON if		
	witnessed, otherwise everything was typed into notes		
	in [electronic health record system]. The DON		
L			1

Page 28 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 led 2/20/25	
Facility Name: Keota Health Care Center		No		Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	- 2024			
Rule or Code Section	Nature of Violation		Class	Fine Amount	Correction date	

statements for witnessed falls were very rare, and		
most if not, all were unwitnessed. When queried		
about root cause analysis, the DON explained do		
follow up when go through the fall incident report.		
When queried where would find root cause, the DON		
explained it was also in the incident report, and did		
not know if it was printed into the incident report or		
not.		
On 11/12/24 at 11:38 AM, Staff E, Registered Nurse		
(RN) queried about the resident's arm/injury. Staff E		
responded the resident had four breaks, and was just		
told she fell. Staff E further explained was not present		
when it happened, and got it in report. Per Staff E, the		
resident normally had a 4-wheel walker with a seat,		
the bearings were out she guessed, and someone got		
the resident a 3 wheeled walker. Staff E explained a		
staff member (Staff I, Certified Nursing Assistant) said		
they were not getting resident up with the 3 wheeled		
walker, and another staff member said the resident		
had used it yesterday fine, and would get her up. Per		
Staff E, Staff I had already said wanted no part in that.		
Staff E queried what she thought about the 3 wheeled		
walkers, and provided the following description: little		
kid's walker, very tiny width, handles, no seat, really		
narrow and didn't look maneuverable. Staff E further		
explained in a conversation with staff member (staff		
member who had previously said not getting resident		
		Dogo 20 of 0

Page 29 of 97

Facility Administrator

Date

Citation Number: #10682					ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248				Survey Dates: November 4, 2024 – November 19 2024	
		СР	2024		
Neola, Iowa (<i>J22</i> 4 0				
Rule or Code Nature of V Section		re of Violation	Class	Fine Amount	Correction date
	Γ				Γ
	up with 3 wheeled wal called it, [Resident #5]	ker), Staff E told Staff I they broke arm.			

	On 11/12/24 at 2:19 PM an interview was completed with Staff D, Licensed Practical Nurse (LPN) who had completed the resident's incident report on 11/1/24. Staff D explained she didn't see it happen, and Staff F, Housekeeping witnessed and brought to attention. Per Staff D, resident in the hall, walked independently with a walker, and had a new walker that Staff D not aware of at all. Resident #5 using a new walker, was normally pretty steady, could have lost balance, and fell right side. Per Staff D, the resident was not in pain, was able to move, and was holding onto a walker with broken arm. Staff D explained Resident #5 pretty much non-verbal, and when ask if in pain the resident doesn't say anything. Staff D further explained with upward motion and bringing Geri sleeve up, the resident cried out in pain. Staff D explained she contacted medics and family, and when the medics got there didn't think the arm was broken, Staff D tugged Geri sleeve again, and the resident screamed in pain. Per Staff D, medics said didn't think was broken and to start x-ray in [Location Redacted], while the other medic felt crepitus. Per Staff D, the resident did have a bump on the head.			
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Page 30 of 97

Facility Administrator

Date

Citation Numb #10682	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР			
Keota, Iowa 52248					
Rule or Code Section	Nature of Violation		Class	Fine Amount	Correction date

On 11/18/24 at 8:54 AM, Staff I, Certified Nursing		
Assistant (CNA) explained, in part, Resident #5 walked		
with a front wheeled 4-wheel walker, because she		
could not do a 3-wheeler had never been trained on		
it. When queried if Resident #5 ever had a 3 wheeled		
walker, Staff I responded two weeks ago before fall		
had the bearing going out of her (Resident #5's)		
walker and maintenance gave her a 3-wheel walker.		
Per Staff I, she thought the resident got the walker on		
a Thursday, Staff I had worked that night 10 to 6, and		
Friday morning the resident had it sitting there. Staff I		
explained she did not get Resident #5 out of bed		
because Staff I did not feel comfortable. Per Staff I,		
that morning (Resident #5) fell. Staff I explained		
Resident #5 was like a "cylinder" and Staff I did not		
feel comfortable to use the 3-wheel walker. Per Staff I,		
the resident stayed in bed until the day shift got her		
up, and Staff I asked the nurse if was ok to leave		
Resident #5 in bed until the day shift as there were no		
notes for her to use it (3-wheel walker). Staff I		
explained just played it safe. When queried about		
communication would occur, Staff I explained usually		
in nurses' notes, and during report when walked in		
room checked resident if something different, then		
would ask the nurse. Per Staff I, she passed it to day		
shift, and they said would check into it.		

Page 31 of 97

Facility Administrator

Date

Citation Number: #10682					ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР			
Rule or Code Nature Section		re of Violation	Class	Fine Amount	Correction date

Observation on 11/05/24 at 12:36 PM revealed		
Resident #5 in the common area with bruising present		
to the right side of the resident's head. Resident had		
green bruise to right forehead. No staff observed in		
line of sight of the nursing desk/common area at time		
of observation. There was a housekeeping staff		
observed in the North hall. Other staff not observed		
to be present.		
Observation on 11/13/24 at 9:59 AM revealed		
Resident #5 in wheelchair in the common area.		
On 11/13/24 at 12:13 PM, the Maintenance		
Supervisor interviewed about Resident #5's walker.		
Per the Maintenance Director, somebody said the		
resident's walker wheels were acting weird, the		
Maintenance Supervisor looked at it, and the bearings		
were popped out. The Maintenance Supervisor		
explained found other one (walker) that had brought		
in. The Maintenance Supervisor described the walker		
with the bearings popped out as a walker with 4		
wheels with handles and breaks on it. The		
replacement walker was described as follows by the		
Maintenance Supervisor: Had same stance, 3 wheels,		
and had break cables like the resident was used to.		
When queried if facility had any 4-wheel walkers		
available, the Maintenance Supervisor responded just		

Page 32 of 97

Facility Administrator

Date

Citation Number: #10682					ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР			
Rule or Code Nature Section		re of Violation	Class	Fine Amount	Correction date

the ones without wheels that put tennis balls on. The		
Maintenance Supervisor queried not like the walker		
the resident had, and confirmed. Per the		
Maintenance Supervisor, he was not sure where the 3		
wheeled walkers came from, it was in facility's		
storage. When queried if any staff expressed concerns		
with using the 3 wheeled walker for the resident, the		
Maintenance Supervisor denied, and explained he		
adjusted the handles down to meet the height of the		
resident's old one (walker) so it was the same height.		
On 11/19/24 at 2:56 PM the facility's Administrator		
explained was not the fault of the walker, was the		
fault of her (Resident #5's) feet. Per the Administrator,		
had done education about with any change in		
equipment, maintenance, therapy, and the DON		
review. The Administrator then explained she was not		
sure the cause was related to the resident's footing.		
When queried regarding an evaluation for a resident's		
new piece of equipment, the Administrator explained		
should be evaluated by therapy. When queried if		
there should be an evaluation when going from 4		
wheel to 3-wheel walker, the Administrator		
responded yes.		
b. Review of Resident #5's Care Plan dated 4/2/21 and		
revised 2/15/24 revealed, [Resident #5] requires assist		
with ADL's (activities of daily living) due to impaired		

Page 33 of 97

Facility Administrator

Date

Citation Number: #10682					ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024			
Rule or Code Natur Section		ure of Violation	Class	Fine Amount	Correction date	

 mobility, recent hip fx (9/2023), Alzheimer with dementia, diabetes mellitus, anemia, edema, neurogenic bladder, atrophy of muscles, depression/anxiety, TIA & CVA. The Intervention revised on 9/10/24 revealed, ASSISTIVE DEVICES: w/w (wheeled walker); w/c (wheelchair) PRN (as needed) for appointment. Observation conducted 11/5/24 at 12:41 PM revealed 		
Staff C, Certified Nursing Assistant (CNA) assisted Resident #5 down the hallway in the wheelchair, and the resident's right foot observed off of the foot pedal and skimmed across the floor while the resident was assisted.		
2. Review of the Minimum Data Set (MDS) assessment for Resident #22 dated 6/21/24 revealed the resident scored 1 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated the resident severely cognitively impaired. Per the assessment, the resident had not had any falls since admission, entry, reentry, or prior assessment, had physical behavioral symptoms 1-3 days, had verbal behavioral symptoms 4-6 days, and other behavioral symptoms 1-3 days, and wandered 1-3 days.		
The resident's MDS dated 9/18/24 revealed the resident scored 00 out of 15 on BIMS exam, which		

Page 34 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР			
Rule or Code Nature o Section		re of Violation	Class	Fine Amount	Correction date

indicated severely impaired cognition. Per this assessment, Resident #22 had falls since admission, entry, reentry, or prior assessment, two with no injury and two with injury (except major).		
The Care Plan dated 6/17/24 revised 10/14/24 revealed, [Resident #22] is at risk for falls and has had a fall related to impaired balance, poor safety awareness, functional impairment and the use of medications that may increase falls risks.		
 a. 6/17/24 Fall with injury b. 6/24/24 Fall without injury c. 7/2/24 Fall without injury d. 7/5/24 Fall without injury e. 9/3/24 Fall with skin tear f. 9/30/24 unwitnessed fall without injury g. 10/9/24 unwitnessed fall without injury h. 10/14/24 witnessed fall with skin tear 		
Interventions per Resident #22's Care Plan included the following:		
 a. (Initiated 7/2/24, revised 9/10/24): Dycem placed below and on top of cushion in wheelchair. b. (Initiated 9/30/24): Educate and encourage family visits for orientation purposes. 		

Page 35 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР			
Rule or Code Nature of Violation Section		e of Violation	Class	Fine Amount	Correction date

 c. (Initiated 9/30/24): Educate family about fall risks and increased weakness due to resident weight loss and refusal to eat much at meal or snack times. d. (Initiated 6/17/24, revised 6/19/24): Ensure [Resident #22] is wearing appropriate footwear when ambulating or utilizing their wheelchair. Resident prefers to wear open toe shoes. e. (Initiated 6/19/24, revised 9/10/24): Fall mat at bedside. f. (Initiated 6/17/24): Follow all facility protocol related to falls ie: initiation of neuros (if applicable), fall report/investigation, immediate interventions and long-term interventions, informing of physician/family. g. (Initiated 6/17/24, revised 9/10/24): Gripper socks in place when out of bed. h. (Initiated 7/5/24, revised 9/10/24): [Resident #22] was given a different wheelchair. i. (Initiated 10/14/24): Offer and encourage resident to rest between meals or when she appears drowsy in wheelchair. j. (Initiated 10/17/24, revised 9/10/24): PT/OT (physical therapy/occupational therapy) to eval and treat if appropriate due to fall. k. (Initiated 10/9/24): Reorient resident to her own room and belongings any time that she is found in the hallways. 	 •		
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	k. (Initiated 10/9/24): Reorient resident to her own		
hallways.			
	hallways.		

Page 36 of 97

Facility Administrator

Date

Citation Number: #10682 Facility Name: Keota Health Care Center Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248 Rule or Code Natu					ber 10, 2024 ed 2/20/25
			Survey Dates: November 4, 2024 – November 19, 2024		
		СР	2024		
		re of Violation	Class	Fine Amount	Correction date
Section					
	•	rised 9/10/24): Staff to check on nen in the area that resident is			

Review of Incident Reports and the clinical record for Resident #22 revealed the following:

The Incident Report dated 6/17/24 at 9:00 AM revealed, this nurse was in another resident's room when I heard a yell, walked out the door, resident sitting on floor near North hall back door, with back against wall...R (right) leg moved without pain, L (left) leg-hip pain. Dr. notified, verbal orders to send resident to ER (Emergency Room) for evaluation and treat for pain to L hip. A predisposing situation factor was improper footwear. The Immediate Action Taken section revealed, ask the family about replacing shoes. Discharge instructions from the Emergency Department dated 6/18/24 at 9:47 AM revealed, L (left) hip fx (fracture)-nonsurgical, walk with walker.

Discharge instructions from the Emergency Department dated 6/18/24 at 9:47 AM revealed, L (left) hip fx (fracture)-nonsurgical, walk with walker. Review of the Physician Note dated 6/20/24 revealed, in part, the following for Resident #22: Alert and oriented to person. Dementia. Episodes of confusion and disorientation. She has been having delusions about her medications and staff...She has a history of osteoporosis and hip fractures...She was sent to the

Page 37 of 97

Facility Administrator

Date

Citation Number: #10682 Facility Name: Keota Health Care Center Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248					ber 10, 2024 ed 2/20/25
			Survey Dates: November 4, 2024 – Novem		ember 19,
		СР	- 2024		
Rule or Code Section	Nat	ture of Violation	Class	Fine Amount	Correction date
	and was found to ha	artment) after a fall on 6/17/24 ve a left hip fracture. Uncertain if ious fracture. It was non-surgical.			
	•	ted 6/19/24 at 1:02 PM revealed, Il mat next to bed, gripper socks			

The Nursing Note dated 6/19/24 at 1:02 PM revealed, Fall Interventions: fall mat next to bed, gripper socks on at all times when out of bed, PT/OT eval and treat if appropriate.		
The Incident Report dated 6/24/24 at 5:05 PM revealed, was called to room [number redacted] to find resident sitting on her hands and knees in front of the bathroom facing the bathroom in front of her w/c (wheelchair). The Immediate Action Taken section revealed, in part, was helped by 2 CNAs and gait belt to her w/c then she was transferred to the bathroom, resident was then brought to the nurses' station where this writer was able to have one on one with resident, to help with redirecting of resident.		
The Incident Report dated 7/2/24 at 10:45 AM revealed, Resident was wheeling herself down the west hallway, the 2nd door on the left she tried to open, shaking the door handle, when it didn't open resident slid herself, cushion and all to the floor. Witnessed by an activity aide, resident, didn't hit head. The Immediate Action Taken section revealed,		

Page 38 of 97

Facility Administrator

Date

Citation Numb	er:	Date: December 10, 202 Amended 2/20/25			•	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024			
Rule or Code Nature of Violat Section		re of Violation	Class	Fine Amount	Correction date	

Place dycem below cushion in wheelchair and on top of cushion in wheelchair.
The Incident Report dated 7/5/24 at 1:28 PM revealed, Activity director notified this nurse of resd seated on the floor at 1328 (1:28 PM). Resd previously exit seeking. Resd observed by front lobby entrance seated in front of w/c on w/c cushion dycem in place below et (and) on-top of w/c cushion. AROM (active range of motion) intact, x3 skin tears to outer rt (right) forearm from elbow down 1.7x1cm, 2x1cm, 0.8x0.5cm, areas cleansed with steri strips put in place. The Immediate Action Taken section revealed, New w/c provided that is more suitable for dycem to prevent sliding out. Review of a Fax dated 7/25/24 revealed, in part, post fall injuries x3 skin tears from elbow down to rt (right) outer forearm 1.7x1cm, 2x1 cm, 0.8x0.5cm areas cleansed et approximated c (with) steri strips. The Immediate Action Taken section revealed, New w/c provided that is more suitable for
dycem to prevent sliding out. The Incident Report dated 8/22/24 at 1:43 PM revealed, this nurse was called to the reception/lobby area. Resident suffered an unwitnessed fall. [Resident #22] was lying flat on the floor with legs out. Blood noted on right side of forehead with bruising. Bleeding stopped by providing pressure to the area.

Page 39 of 97

Facility Administrator

Date

Citation Numb	er:	Date: December 10, 202 Amended 2/20/25			•
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024		
Rule or Code Nature of Violation Section		e of Violation	Class	Fine Amount	Correction date

	esident voices complaints of pain from hitting their ead on the floor. The Immediate Action Taken		
se	ction revealed, Resident wearing sandals at time of		
	cident, sandals removed and resident allowed grip ocks to be placed.		
Re	eview of the Nursing Note for Resident #22 dated		
8/	22/24 at 1:43 PM revealed, in part, this nurse was		
са	lled out to reception/front lobby. [Resident #22]		
Wa	as noted to be lying on the floor with legs		
ou	utstretched near chairs/table. Blood noted on the		
lef	ft forehead. Staff and other residents reporting she		
fel	II. Staff did not witness the event.		
	ne N-Weekly Non-Pressure Wound Assessment V2		
	orm completed 8/22/24 at 3:52 PM revealed the		
	llowing: FYI (for your information) post fall skin		
	sessment was written on the form. A wound was		
	ocumented to the resident's face described as		
	llows: rt (right) orbital 1.3x0.3cm (centimeter)		
lac	ceration with surrounding bruise of 7x7cm.		
Re	eview of Resident #22's Care Plan to address falls		
_	cked documentation of the resident's fall with injury		
	the list of resident's falls in the focus area of		
Re	esident #22's Care Plan, and lacked any interventions		
	Ided in August 2024.		
	-		

Page 40 of 97

Facility Administrator

Date

Citation Numb	per:	Date: December 10, 2 Amended 2/20/			•
Facility Name: Keota Health Care Center Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248			Survey Dates: November 4, 2024 – November 19, 2024		
		СР	2024		
Rule or Code Nati Section		ure of Violation	Class	Fine Amount	Correction date

The Incident Report dated 9/3/24 at 3:44 PM revealed, called 15:30 (3:30 PM) to North hallway, unwitnessed fall, when resident was with Administrator and another resident standing nearby. Resident was standing and talking when I started initial assessment. Resident denies pain of discomfort at this time Skin tear to right upper arm 5" x1.5". The Immediate Action Taken section documented an assessment of the resident.		
Review of a Fax dated 9/3/24 at 3:50 PM revealed, in part, unwitnessed fall skin tear to right arm.		
The Fall-Initial Note dated 9/3/24 at 3:30 PM revealed the following cause: Unwitnessed fall due to confusion.		
The Incident Report dated 9/30/24 at 2:35 PM revealed, this nurse heard a loud thud, entered the lobby to find a resident laying on her right side with her wheelchair tipped over top of her. The Immediate Action Taken section revealed, ROM (range of motion) assessed without any abnormal range of motion observed or reported. Resident assisted with x2 assist to wheelchair. Resident denies pain.		

Page 41 of 97

Facility Administrator

Date

Citation Number: #10682					ber 10, 2024 <mark>ed 2/20/25</mark>	
Facility Name: Keota Health Care Center Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248			Survey Dates: November 4, 2024 – November 19, 2024			
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Rule or Code Section	Code Nature of Violation		Class	Fine Amount	Correction date	

	 1	
Review of a Fax dated 9/30/24 at 2:35 PM revealed,		
unwitnessed fall from wheelchair. no injuries		
observed at this time. Will monitor per policy.		
Review of the Fall Risk Evaluation dated 9/30/24		
revealed Resident #22 scored 17 on the assessment,		
which indicated high risk.		
The Incident Report dated 10/9/24 at 12:45 PM		
revealed, this nurse alerted by housekeeping that this		
R (resident) was on the floor and the drawers on		
other R dresser were open and (et) R arm was in one		
sleeve of jacketR was helped up into her wheelchair		
et back to her room et laid down. R is unable to		
respond correctly as is her usual. The Immediate		
Action Taken section revealed, R (resident) helped off		
floor and taken to bed. Per the Incident Report, a		
predisposing situation factor was bare feet or		
inappropriate footwear.		
The Fall Risk Evaluation dated 10/9/24 revealed		
Resident #22 scored 21 on the assessment, which		
indicated high risk for falls.		
The Incident Depart dated 10/12/24 at CO2 DM		
The Incident Report dated 10/13/24 at 6:02 PM		
revealed, Resident sitting in w/c by nurses' desk,		
slipped to floor hitting left elbow on wall on the way		
down. The Immediate Action Taken section revealed,		

Page 42 of 97

Facility Administrator

Date

			ber 10, 2024 <mark>ed 2/20/25</mark>	
	Survey Dates: November 4, 2024 – November 19, 2024			
СР				
re of Violation	Class	Fine Amount	Correction date	
		CP Novemb	CP	

Vitals, assisted back into w/c cleansed and applied dressing to elbow.		
The Fall Risk Evaluation dated 10/13/24 revealed Resident #22 scored 25 on the assessment, which indicated high risk.		
Observation on 11/13/24 at 10:02 AM revealed Resident #22 tilted back in broda chair in the television area/nursing station in the front of the facility.		
On 11/13/24 at 9:09 AM, Staff C, Certified Nursing Assistant (CNA) queried if at facility when Resident #22 had fallen, and responded she was sure she was. Staff C explained now the resident did not ambulate at all, and explained the resident went downhill really fast. Staff C explained she thought a lot of the resident's falls happened on the weekends. When queried how fall risk was communicated, Staff C explained usually through the nurses on report. When queried if the resident's current wheelchair was from hospice, Staff C acknowledged it was. Staff C explained the resident was in a regular wheelchair before, and wasn't working out too well. Staff C		
explained the resident was leaning over and leaning too forward, and was so much comfier in chair and looked so much better in it too.		

Page 43 of 97

Facility Administrator

Date

Citation Numb	er:	Date: December Amended 2			ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР				
Keota, Iowa 52248						
Rule or Code Natur Section		re of Violation	Class	Fine Amount	Correction date	

On 11/12/24 at 12/EE DNA Staff C. Degistered Nurse		
On 11/13/24 at 12:55 PM, Staff G, Registered Nurse		
(RN) explained when she first went to the facility,		
resident was walking. Staff G explained not having		
enough staff at the facility because they were all out		
on break instead of watching residents. Per Staff G,		
she had CNAs on break all the time not telling that		
they went on break. Per Staff G, the resident started		
failing and was put on hospice. When queried if she		
had ever worked when the resident had fallen, Staff G		
denied. When queried about increased monitoring for		
the resident, Staff G responded just the behaviors,		
explained the resident had tried to bite a staff		
member when intervened, and further explained		
made sure to keep an eye on her and know where		
was at, at least where located.		
On 11/18/24 at 10:36 AM, interview conducted with		
Staff J, CNA regarding Resident #22 and falls. When		
queried if she had been at facility when Resident #22		
had fallen, Staff J replied always. Per Staff J, when		
resident first at facility would walk, would put self on		
the floor, and was care planned now for laying on the		
floor. When queried if Resident #22 was someone		
who could be left in the common area without staff		
watching her, Staff J responded no, and further		
explained the resident still had energy and strength to		
sit self-up, and personally she wouldn't do so. Staff J		

Page 44 of 97

Facility Administrator

Date

Citation Numb	er:	Date: December 10 Amended 2/2			•
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР	2024		
Keota, Iowa 52248					
Rule or Code Nature Section		re of Violation	Class	Fine Amount	Correction date

explained now resident in a wheelchair, and have caught her trying to stand up to side of wheelchair, trying to dangle legs. Staff J explained when the resident used to have an actual wheelchair she would		
get up and start walking down the hallways, and now the resident had a reclining wheelchair.		
On 11/18/24 at 8:59 AM, Staff I, CNA acknowledged Resident #22 had fallen a couple of times, and not for Staff I. Staff I explained when resident at the front desk liked to climb out of Geri chair, and eased self-down or sat down. When queried what the resident tried to do, Staff I explained the resident was busy, felt needed to go shopping, traveling, and was in her own world. Staff I further explained the resident had their current chair for a month/month and a half, and could get out of it. Per Staff I, even though it tilted rolled off to the side, and explained the resident was very agile. When queried about watching persons in the lobby, Staff I explained it depended upon who it was, and explained the following pertaining to Resident #22: If people like [another resident redacted] or [Resident #22], tried to keep someone up there behind the desk, a couple times would get laundry to have them help fold towels, and keep them busy, get them out of their bubble so not so agitated.		

Page 45 of 97

Facility Administrator

Date

Citation Numb	er:	Date: December 1 Amended 2			ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР	2024			
Keota, Iowa 52248						
Rule or Code Natur Section		re of Violation	Class	Fine Amount	Correction date	

On 11/19/24 at 2:59 PM, the Administrator queried if she had been at facility when Resident #22 had fallen, and denied. The Administrator explained for the last six to eight weeks the resident had been pretty much wheelchair bound.		
3. On 11/6/24 at 6:06 a.m., Staff B Licensed Practical Nurse (LPN) placed Resident #6's Lisinopril (a blood pressure medication) 5 milligrams(mg) and Olanzapine (an antipsychotic) 10 mg into a medication cup and placed it on top of the medication cart. Staff B left the medication cart and entered the medication room and closed the door. The Director of Nursing (DON) was present on the other side of the nursing station but left the vicinity for approximately 1 minute. When the DON returned, Staff B was still in the medication room. The DON picked up the medications and when Staff B returned to the cart, she handed the medications back to her.		
Untitled facility lists documenting cognitive status and mobility, listed 13 cognitively impaired, independently mobile residents. The facility policy "Storage of Medications", revised 4/2007, stated the facility would store all drugs in a safe, secure, and, orderly manner.		

Page 46 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР	2024		
Keota, Iowa 52248					
Rule or Code Natur Section		re of Violation	Class	Fine Amount	Correction date

On 11/19/24 at 1:57 p.m., the Administrator stated medications should not be left unattended.		
4. The Minimum Data Set (MDS) assessment tool, dated 3/14/24, listed diagnoses for Resident #2 which included seizure disorder, anxiety disorder, and depression. The MDS stated the resident required partial to moderate assistance to transfer from chair to bed and listed his cognitive skills for daily decision making as moderately impaired.		
Care Plan entries, dated 5/17/13, stated the resident had the potential for uncontrolled seizures resulting in a safety hazard and falls and stated he would have no major injury related to his seizure disorder.		
An 8/1/19 Care Plan entry directed staff to keep a gait belt on the resident when he stood while dressing and to keep ahold of him by the gait belt so he could be assisted if he lost his balance.		
A 9/16/20 Care Plan entry directed staff to quickly assist the resident to lie down if he felt a seizure coming on.		
A 10/25/21 Care Plan entry stated the resident required the assistance of one staff member for transfers.		

Page 47 of 97

Facility Administrator

Date

Citation Numb #10682	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР			
Keota, Iowa 52248					
Rule or Code Nature of Violation Section		e of Violation	Class	Fine Amount	Correction date

Care Plan entries, dated 4/11/22, directed staff to not leave the resident alone during a seizure and protect from injury. The Care Plan directed staff to help the resident to the floor to prevent injury if the resident was not in bed.		
Care Plan entries, dated 6/24/24, stated the resident was at risk for falls related to impaired balance, poor safety awareness, neuromuscular/functional impairment, and the use of medications that may increase fall risks related to a diagnosis of seizure disorder. The entries directed staff to encourage him to ask for assistance when transferring, check on him frequently, and offer assistance with any activities of daily living (ADLs).		
 a. Resident #2 Falls A 5/12/24 BHCP-Falls9 Report stated a Certified Nursing Assistant (CNA) assisted the resident to transfer from the wheelchair to the bed and he lost his balance and fell to the side. The CNA was unable to stop his fall and was not using a gait belt during the transfer. The resident sustained a bruise to the left iliac crest (the upper portion of the frontal pelvic bone). 		

Page 48 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 led 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР	2024		
Keota, Iowa 52248					
Rule or Code Nature of Violation Section		e of Violation	Class	Fine Amount	Correction date

A 6/22/24 6:22 p.m. Incident Note stated the resident placed his call light on during meal time and the nurse		
left to get assistance as when the resident requested to be laid down he was not always stable and also		
possibly requested to lie down when feeling the onset		
of seizures. The nurse and CNA walked to the		
resident's room when they heard a loud bang. The resident laid between the bed and the TV and a large		
amount of blood pooled on the floor. Staff called 911		
and the resident transferred to the ER.		
A 6/22/24 9:40 p.m. Incident Note stated the resident		
returned to the facility and the hospital treated him		
for a scalp laceration and possible seizure. The		
resident returned to the facility with staples.		
The Care Plan lacked documentation of an		
intervention related to the above falls in order to		
prevent future falls.		
On 11/7/24 at 11:49 a.m., Staff N CNA stated Resident		
#2 required a gait belt with transfer assistance.		
On 11/13/24 at 8:38 a.m., Staff D Licensed Practical		
Nurse (LPN) stated (on 6/22/24) Resident #2 waved		
his hands when he wanted to lie down. She stated		
she left to get help because she did not want to help		
him by herself. She stated it was a busy time so she		

Page 49 of 97

Facility Administrator

Date

Citation Numb	er:	Date: December Amended			
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР	2024		
Keota, Iowa 52248					
Rule or Code Section	Code Nature of Violation		Class	Fine Amount	Correction date

returned 10-15 minutes later. She stated she and other staff were outside the door when he fell. She stated there was enough staff but the CNAs were feeding residents at the time.		
On 11/13/24 at 3:06 p.m., the Director of Nursing (DON) stated Resident #2 should transfer with a gait belt. She stated when a resident fell, staff looked at why they fell and developed an intervention.		
On 11/19/24 at 1:59 via phone, the DON of a sister facility stated if staff thought a resident was having a seizure, they would prioritize this even if they were busy. She would want staff to put them in bed and tell the nurse.		
b. Resident #2 Wheelchair Safety		
On 11/5/24 at 8:56 a.m., Staff M CNA pushed Resident #2 in the wheelchair from his room to the shower room. The resident's wheelchair did not have attached foot pedals and the resident's feet hung down towards the floor.		
The facility policy "Transporting a Resident via Wheelchair", adopted 5/2024, stated for safety purposes, staff would not transport residents in wheelchairs without the use of leg rests.		

Page 50 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 led 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР			
Keota, Iowa 52248					
Rule or Code Section	Nature of Violation		Class	Fine Amount	Correction date

On 11/19/24 at 1:59 via phone, the DON of a sister facility stated when staff pushed residents in a wheelchair, they should make sure feet rested on foot pedals.		
5. The MDS assessment tool, dated 12/10/23, listed diagnoses for Resident #3 which included non-Alzheimer's dementia, psychotic disorder, and depression. The MDS listed his BIMS score as 7 out of 15, indicating severely impaired cognition.		
Care Plan entries, dated 1/1/24, stated the resident had impaired cognitive function or impaired thought processes related to frontal lobe dementia, had difficulty with the ability to understand others, and had impaired decision making. The entries stated the resident required verbal cueing and direction during activities and directed staff to supervise the resident.		
A 5/3/24 Order Note stated the resident swallowed a raw, whole robin's egg and received direction from the provider to monitor for salmonella (a bacteria which could be present on bird eggs) and stomach upset.		
On 11/13/24 at 8:38 a.m., Staff D LPN stated the facility found a robin's egg outside and brought it in to		

Page 51 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 led 2/20/25
Facility Name: Keota Health Care Center Facility Address/City/State/Zip 204 N Keokuk Washington Rd			Survey Dates: November 4, 2024 – November 19, 2024		
		СР			
Keota, Iowa 52248					
Rule or Code Section	Code Nature of Violation		Class	Fine Amount	Correction date

show the residents. They passed it around and Resident #2 put it in his mouth and swallowed it whole. She called the doctor and monitored him after the incident.		
On 11/19/24 at 1:59 via phone, the DON of a sister facility stated she would not pass around a robin's egg unless it were cleaned so it was free of bacteria. She stated with residents who had dementia, she was not sure because she didn't want them sticking it in their mouths.		
6. The MDS assessment tool, dated 10/30/24, listed diagnoses for Resident #21 which included Parkinson's (a disease which caused symptoms such as tremors), arthritis, and diabetes. The MDS stated the resident was independent with walking and toileting and listed the resident's BIMS score as 0 out of 15, indicating severely impaired cognition.		
A 10/31/23 Care Plan entry stated the resident was at risk for falls related to Parkinson's.		
A 4/17/2024 6:00 a.m. Nursing Note stated the resident laid on the bathroom floor and there were briefs and a towel on the bathroom floor.		
A 4/17/24 6:31 a.m. Nursing Note stated the resident		

Page 52 of 97

Facility Administrator

Date

Citation Numb	er:	Date: December 10, 2 Amended 2/20/			•
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР			
Reola, Iowa 52240					
Rule or Code Section	Code Nature of Violation		Class	Fine Amount	Correction date

complained of right rib pain and the facility obtained an order for an x-ray.		
A 4/18/24 1:48 p.m. eMar-Medication Administration Note stated the x-ray revealed no fractures.		
A 4/19/24 9:58 p.m. Order Note stated the resident cried and complained of rib pain.		
A 6/21/2024 9:01 a.m. Nursing Note stated the resident was on the floor near the doorway to her room with blood coming from her forehead. The resident had a laceration deep enough to require stitches or staples.		
A 6/21/24 10:06 p.m. Nursing Note stated the resident's husband also fell and Resident #21 transferred to the ER due to her head laceration.		
A 6/21/24 Care Plan entry stated the resident moved to a separate room from her husband to prevent them from leaning on each other.		
A 6/22/24 1:55 a.m. Nursing Note stated the resident returned to the facility and was treated at the ER for a forehead laceration.		
An 11/17/24 Incident Note stated staff heard a "thud"		

Page 53 of 97

Facility Administrator

Date

Citation Numb	er:	Date: December 10 Amended 2/2			•
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР			
Reola, IOwa 52240					
Rule or Code Section	Nature of Violation		Class	Fine Amount	Correction date

and the resident laid on the floor near the doorway to the bathroom. The resident had a hematoma(bruise) to the left side of the forehead and the facility received an order to transport to the ER.		
An 11/17/24 Nursing Note stated the resident sustained left humerus (upper arm bone) and left hip fractures and admitted to the hospital.		
The Care Plan lacked further documentation of root cause analysis of the previous falls and additional, specific interventions related to the prevention of future falls.		
On 11/19/24 at 11:59 a.m. via phone, the DON of a sister facility stated if a resident had a fall, they would conduct a root cause analysis to find out what caused the fall. They would complete teaching and education. They would decide a root cause and go from there to formulate interventions.		
The facility policy "Falls Management System", revised 9/2022, stated the facility would provide an environment that remained as free of accident hazards as possible. The facility would provide each resident with appropriate evaluations and interventions to prevent falls. After each fall, the facility updated the care plan to include the fall and		

Page 54 of 97

Facility Administrator

Date

Citation Number: #10682				De		er 10, 2024 d 2/20/25
Facility Name Keota Health		-	Survey Novemb 2024	Dates: ber 4, 2024 –	- Nove	mber 19,
	ess/City/State/Zip < Washington Rd 52248	СР	2024			
	T			1		
Rule or Code Section	Natu	re of Violation				Correction date
	address those element	. Care Plan interventions would				
	investigation as probat	-				
	contributed to the fall.					
		ident abuse prohibited. Each				
58.43		ind and considerate care at all	CLASS	\$500.00		UPON
		from mental, physical, sexual, oitation, neglect, and physical	П	HELD IN SUSPENSIO		RECEIPT
	injury.	onation, neglect, and physical		JUJFENJIC		
	DESCRIPTION:					
		interview, and record review,				
		otect the resident's right to be for two of twelve residents				
		esident #12, Resident #19).				

Page 55 of 97

Facility Administrator

Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Resident #12, was a severely cognitively impaired resident with a previous history of unsolicited sexual touching. On 10/26/24, Resident #12, was touched on the breast underneath her clothing by Resident #19. On an unknown date, Resident #19 touched Resident

#12 on the buttock. On an unknown date, staff

reported Resident #19 grabbed/groped Resident #12. Resident #12's family explicitly instructed the facility staff that they did not consent to Resident #12 engaging in sexual contact with another resident.

Citation Numb	er:			Date: December 10, 2024 Amended 2/20/25		
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024			
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР				
Rule or Code Section	e Nature of Violation		Class	Fine Amount	Correction date	

The facility failed to protect the resident's right to be free from resident to resident physical abuse for 5 of 15 residents reviewed for abuse (Residents #11, #12, #13, #21, #77). Resident #22 hit Resident #77, grabbed and scratched Resident #12, slapped Resident #11, slapped and pinched Resident #13, and grabbed the arm of Resident #2.		
Findings include:		
1. Review of the Quarterly Minimum Data Set (MDS) assessment for Resident #12 dated 9/13/24 revealed the resident scored 5 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident cognitive patterns were documented as inattention which fluctuated and had behaviors described as having delusions.		
Review of Medical Diagnoses for Resident #12 included Wernicke's encephalopathy, dementia with psychotic disorder, dementia with mood disturbance, restlessness and agitation, and delusional disorders.		
Review of Resident #12's Care Plan dated 7/5/23 revealed the following: Trauma Informed Care:		

Page 56 of 97

Facility Administrator

Date

Citation Number: #10682					ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	- 2024		
	.240				
Rule or Code Section	Code Nature of Violation		Class	Fine Amount	Correction date

[Resident #12] is at risk for alterations in my psycho-social well-being related to: Allegation of abuse. History of being the recipient of unsolicited sexual touching.		
Review of Resident #12's Care Plan dated 7/7/24 revealed, [Resident #12] has a Mutual friendship with a resident of the opposite sex. Interventions per the Care Plan included the following:		
 a. (Created 7/7/24, revised 9/10/24): Do not shame or embarrass [Resident #12] for her friendship. b. (Created 7/7/24, revised 9/10/24): If [Resident #12's] friendship escalates beyond hugging/hand holding/sitting together, please redirect in a calm manner and we will re-assess the plan with staff, family and medical advice. c. (Created 7/7/24, revised 9/10/24): Mild affection (hugging/hand holding/sitting together) is acceptable for both families. d. (Created 10/28/24): Per POA: hand holding, sitting 		
together, resident sitting on other male resident's lap, and a gentle kiss on the lips is within her scope for approval of behavior. Please separate residents if behaviors become more sexual in nature such as touching of one another's private areas e. (Created 7/7/24, revised 9/10/24): Report interactions as needed to Charge Nurse.		

Page 57 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024			
Rule or Code Section	Code Nature of Violation		Class	Fine Amount	Correction date	

iew of Progress Notes for Resident #12 revealed following:			
Nursing Note dated 7/4/24 at 6:10 PM revealed, me Redacted] POA (Power of Attorney) aware of resident engaging in activities of hand holding, ging et (and) sitting together with another male d (resident), POA consents to above activity			
iew of the Care Conference note dated 9/3/24 at D PM revealed, in part, [Resident #12] is declining nental status. She is becoming increasingly fused and aggressive with cares. [Resident #12] is			
kets them, or becomes confused by what to do in them and puts them in cups, bowls, or anywhere it she no longer can see them. [Resident #12] is reasingly confused. She is sleeping more and			
no longer sits in the common area or with the cat. Nursing Note dated 10/26/24 at 5:56 PM ealed, CNA (Certified Nursing Assistant) reports to			
	Nursing Note dated 7/4/24 at 6:10 PM revealed, me Redacted] POA (Power of Attorney) aware of resident engaging in activities of hand holding, ging et (and) sitting together with another male d (resident), POA consents to above activity tinuing in public settings, not behind closed doors. iew of the Care Conference note dated 9/3/24 at 0 PM revealed, in part, [Resident #12] is declining nental status. She is becoming increasingly fused and aggressive with cares. [Resident #12] is onger able to take her medications whole, as she kets them, or becomes confused by what to do in them and puts them in cups, bowls, or anywhere is she no longer can see them. [Resident #12] is easingly confused. She is sleeping more and nding a significant amount of time in her room. no longer sits in the common area or with the cat.	Nursing Note dated 7/4/24 at 6:10 PM revealed, me Redacted] POA (Power of Attorney) aware of resident engaging in activities of hand holding, ging et (and) sitting together with another male d (resident), POA consents to above activity tinuing in public settings, not behind closed doors. iew of the Care Conference note dated 9/3/24 at 0 PM revealed, in part, [Resident #12] is declining nental status. She is becoming increasingly fused and aggressive with cares. [Resident #12] is onger able to take her medications whole, as she kets them, or becomes confused by what to do in them and puts them in cups, bowls, or anywhere et she no longer can see them. [Resident #12] is easingly confused. She is sleeping more and nding a significant amount of time in her room. no longer sits in the common area or with the cat. Nursing Note dated 10/26/24 at 5:56 PM ealed, CNA (Certified Nursing Assistant) reports to	Nursing Note dated 7/4/24 at 6:10 PM revealed, me Redacted] POA (Power of Attorney) aware of resident engaging in activities of hand holding, ging et (and) sitting together with another male d (resident), POA consents to above activity tinuing in public settings, not behind closed doors. iew of the Care Conference note dated 9/3/24 at 0 PM revealed, in part, [Resident #12] is declining nental status. She is becoming increasingly fused and aggressive with cares. [Resident #12] is onger able to take her medications whole, as she kets them, or becomes confused by what to do in them and puts them in cups, bowls, or anywhere is she no longer can see them. [Resident #12] is easingly confused. She is sleeping more and nding a significant amount of time in her room. no longer sits in the common area or with the cat. Nursing Note dated 10/26/24 at 5:56 PM ealed, CNA (Certified Nursing Assistant) reports to

Page **58** of **97**

Facility Administrator

Date

Citation Number: #10682					ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР			
	-2-70				
Rule or Code Section	Code Nature of Violation		Class	Fine Amount	Correction date

reached up this resd (resident) shirt et groped her It		
(left) breast while she was standing next to him. These		
2 resd are care planned to have a friendly relationship		
that involve holding hands et hugging. This nurse		
witnessed female resd approach male resd seated in		
lobby, they proceeded to hold hands before this nurse		
had left to attend another resd. CNA separated the 2		
resd. CNA reports that resd was asking where male		
resd went? CNA redirected et kept them apart. When		
female resd asked by this nurse if the male resd had		
touched her breast she states "No." Administrator		
made aware. Called x 2 numbers for POA (Power of		
Attorney) with no answer et (and) left message.		
Review of a Nursing Note dated 10/28/24 at 8:04 AM		
revealed, Spoke with POA [name redacted] regarding		
potential incident from 10/26 where male friend may		
have touched resident's breasts. [POA name		
redacted] verbalizes that hand holding, sitting		
together, resident sitting on other male resident's lap,		
and a gentle kiss on the lips is within her scope for		
approval of behavior. She states to please separate		
residents if behaviors become more sexual in nature		
such as touching of one another's private areas. Care		
plan updated.		
On 11/13/24 at 12:06 PM, Resident #12 observed in		
her room in bed.		

Page 59 of 97

Facility Administrator

Date

Citation Number: #10682					ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024			
Rule or Code Section	Nature of Violation		Class	Fine Amount	Correction date	

On 11/18/24 at 2:10 PM, Resident #12 observed standing up by the nurses' station near the lobby area of the facility.		
2. Review of the Minimum Data Set (MDS) assessment for Resident #19 dated 10/9/24 revealed Resident #19 scored 14 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition.		
Review of diagnoses for Resident #19 included schizophrenia and dementia with anxiety.		
Review of Resident #19's Care Plan dated 7/4/24 and revised 7/5/24 revealed, [Resident #19] has a Mutual friendship with a resident of the opposite sex. Interventions per Resident #19's Care Plan included the following:		
 a. (Initiated 7/5/24, Revised 9/10/24): Do not shame or embarrass [Resident #19] regarding this relationship. b. (Initiated 7/5/24, Revised 9/10/24): If [Resident #19's] friendship escalates beyond hugging/hand holding/sitting together, please redirect in a calm manner and we will reassess the plan with staff, family and medical advice. 		

Page 60 of 97

Facility Administrator

Date

Citation Number: #10682					ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024			
Rule or Code Section	e Nature of Violation		Class	Fine Amount	Correction date	

 c. (Initiated 7/5/24, Revised 9/10/24): Mild affection (hugging/hand holding/sitting together) is acceptable for both families. d. (Initiated 10/28/24): POA (Power of Attorney) [Name Redacted] verbalizes that hand holding, sitting together, female resident sitting this resident's lap, and a gentle kiss on the lips is within his scope for approval of behavior. He states to please separate residents if behaviors become more sexual in nature such as touching of one another's private areas. [POA name redacted] also requests to be made aware if resident's behaviors with female friend appear to become inappropriate and not reciprocated. 		
e. (Initiated 7/5/24, Revised 9/10/24): Report interactions as needed to Charge Nurse.		
f. (Initiated 7/5/24, Revised 9/10/24): This friendship is acceptable as long as [Resident #19] is safe and		
happy		
Review of Progress Notes for Resident #19 revealed:		
The Communication-with Family/NOK/POA dated		
7/4/24 at 6:07 PM revealed, [Name Redacted] POA		
aware of this resident engaging in activities of holding		
hands, hugging et sitting together with another female resd, POA consents to above activity		
continuing in public settings, not behind closed doors.		

Page 61 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
	ss/City/State/Zip Washington Rd 248	СР	2024		
	2-10				
Rule or Code Section	Natur	re of Violation	Class	Fine Amount	Correction date

The Nursing Note dated 10/26/24 at 5:43 PM revealed, CNA reports to this nurse that at around 1555 (3:55 pm) this resident (resd) reached up a female resd shirt and groped her breast while she was standing next to him. These 2 resd are care planned to have a friendly relationship that involve holding hands et hugging. This nurse witnessed female resd approach male resd seated in lobby, they proceeded to hold hands before this nurse had left to attend another resd. No other resd in lobby witnessed event when asked. [Resident #19] was confronted and asked if anything happened when a female resd approached him? resd states "No." when asked if they were holding hands? He states "yeah we were holding hands." Resd was asked if he touched female resd		
anywhere else? states "her back side a little." Resd asked if he reached up female resd shirt? States "no." Administrator made aware. POA [POA Name		
Redacted] made aware.		
The Nursing Note dated 10/28/24 at 8:12 AM revealed, Spoke with POA [Name Redacted] regarding potential incident from 10/26 where resident may have touched female friend resident's breasts. [Name Redacted] verbalizes that hand holding, sitting together, female resident sitting this resident's lap, and a gentle kiss on the lips is within his scope for		

Page 62 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health 0			Survey Novemb 2024	Dates: per 4, 2024 – Nov	ember 19,
	ss/City/State/Zip Washington Rd 2248	СР	2024		
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date

approval of behavior. He states to please separate residents if behaviors become more sexual in nature such as touching of one another's private areas. [Name Redacted] also requests to be made aware if resident's behaviors with female friend appear to become inappropriate and not reciprocated. Care plan updated.		
The Behavior Note dated 11/1/24 at 2:22 PM revealed, Resd inappropriately touched activity director, when confronted that it is not appropriate to touch staff like that, resd becomes upset, made rude comment regarding situation to activity assistant er ignored activity director.		
On 11/6/24 at 9:23 AM, Incident Reports for Resident #19 for the last six months requested via email to the facility's Administrator and Director of Nursing (DON). The Incident Report received did not address any interactions between Resident #12 and Resident #19.		
On 11/6/24 at 1:12 PM, Staff B, Licensed Practical Nurse (LPN) queried if had any residents who were boyfriend and girlfriend. Staff B responded they said that Resident #12 and Resident #19 were allowed to touch, kiss, and said I'm not really sure. Per Staff B, she had not seen them touch each other or speak word to each other. When queried how to know what		

Page 63 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health C			Survey Novemb 2024	Dates: per 4, 2024 – Nov	ember 19,
	ss/City/State/Zip Washington Rd 248	СР	2024		
	2-10				
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date

was appropriate, Staff B responded she believed the
POA said ok to do those things for both of those two.
On 11/12/24 at 11:47 AM during an interview with
Staff E, Registered Nurse (RN), Staff E explained
Resident #12 and Resident #19 were not a couple, and
were friends. Per Staff E, up until recently the
residents had no notice of each other. Resident #19
started talking to Resident #12, and Resident #12
talking, not daily. Staff E explained they would hold
hands, nothing had happened, and Staff E didn't think
Resident #12 would let it as Resident #12 was very
prim and proper. Per Staff E, one day she was working
second or day shift, and Resident #19 went down to
Resident #12's room. Staff E responded to situation,
and Resident 19 exited. When queried if ever heard of
touching over or under clothes, Staff E responded no.
On 11/12/24 at 2:27 PM, Staff D, Licensed Practical
Nurse (LPN) explained the following about Resident
#12 and Resident #19: Per Staff D, she (Staff D) was
the one that brought to the DON's attention, ok with
family, because kept on doing stuff holding hands,
hugging. Per Staff D, had gotten approval from family
that ok for friendly relationship, peck on the lips, sit
with each other, hold hands, and nothing behind
closed doors. Staff D explained Resident #12 would
seek Resident #19 out, and Resident #19 calmed

Page 64 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health 0			Survey Novemb 2024	Dates: per 4, 2024 – Nov	ember 19,
	ss/City/State/Zip Washington Rd 2248	СР	2024		
	.240				
Rule or Code Section	Natu	re of Violation	Class	Fine Amount	Correction date

Resident #12 down. Staff D explained an aide said he		
saw Resident #19 reach up Resident #12's shirt. Staff		
D further explained the aide did not want them		
(residents) to be together because the aide thought		
Resident #12 could not make decisions for herself. The		
aide was identified as Staff H. When queried if		
Resident #12 had ever had a negative reaction, Staff D		
responded no. Per Staff D, she had never seen		
Resident #19 pursue Resident #12, and when she saw,		
Resident#12 went to Resident #19.		
On 11/13/24 at 12:22 PM, Staff H, Certified Nursing		
Assistant (CNA) explained the following about		
Resident #12 and Resident #19: Staff H explained they		
had seen interactions between Resident #12 and		
Resident #19 on two or three different times, and		
Resident #19 had inappropriately touched Resident		
#12 in some way. Per Staff H, Resident #12 stood		
there not doing anything, Resident #12 would bring		
herself to Resident #19, and needed to separate		
constantly and redirect to keep them away from each		
other. Staff H further explained they thought only one		
time Resident #19 grabbed Resident #12's breast, and		
they thought occurred the weekend of October		
26/27. Per Staff H, another time Resident #19 grabbed		
Resident #12's butt. A third time, Staff H did not		
remember if Resident #19 grabbed or "groped",		
Resident #19 did touch Resident #12 and Staff H did		
	•	

Page 65 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health C			Survey Novemb 2024	Dates: per 4, 2024 – Nov	ember 19,
	ss/City/State/Zip Washington Rd 248	СР	2024		
	2-10				
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date

not remember how. Staff H provided the following details about when Resident #12's incident with breast touching: Staff H explained the grabbing of Resident #12's breast was under the clothes with full		
arm up When gueried how Staff H knew what interactions		
were appropriate, Staff H explained they did not need a degree to see inappropriate anywhere. Staff H explained don't need to be grabbed/groped. Staff H		
explained they reported all of them (incidents) to staff at facility. When queried which Staff H talked to, Staff H responded the Director of Nursing (DON) one time,		
then talked to the floor nurses every time. Staff H further explained Resident #12 would just stand there and let Resident #19 do everything. When queried if		
Resident #12 said anything when it was happening, Staff H responded no.		
On 11/13/24 at 1:07 PM, Staff G, RN queried about any interactions between Resident #12 and Resident #19, responded yes, explained the DON said was ok,		
and Staff G thought inappropriate. Staff G explained Resident #12 sat on Resident #19's lap right in the		
middle of the day hall with all the residents there. Staff G explained she (Staff G) thought probably not good idea related to behaviors, and if approved by		
family, ok she supposed. Staff G explained the DON		

Page 66 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health (Survey Novemb 2024	Dates: oer 4, 2024 – Nov	ember 19,
	ss/City/State/Zip Washington Rd	СР	2024		
	.240				
Rule or Code Section	Nati	ure of Violation	Class	Fine Amount	Correction date

said had it approved by families could see each other.		
Staff G explained Resident #12 was not really "with		
it". Per Staff G, it wasn't like sitting beside him		
(Resident #19) holding hands, was sitting on his		
(Resident #19's) lap. Staff G further explained she had		
told CNAs (Certified Nursing Assistants) why don't let		
divert these two, and got their attention somewhere		
else, which was easy to do.		
On 11/14/24 at 1:56 PM, the Administrator		
responded Resident #19 and Resident #12 were		
friends, the Administrator explained had heard		
holding hands came to light. The Administrator		
acknowledged not aware of touching of the resident's		
breast and butt. Per the Administrator, if unaware of		
touching of the resident's breast, then could not		
report.		
On 11/18/24 at 9:03 AM, Staff I, CNA queried about		
how Resident #12 and Resident #19 interacted. Staff I		
explained, part, Resident #12 was very sweet, and		
Staff I explained Resident #19 would take advantage		
of someone who's medicated. When queried what		
Staff I meant by take advantage, Staff I responded, like		
touch, explained I'm sitting beside you where would		
my hands go, and further explained I'm your friend		
can we take a walk. Staff I explained she got that		

Facility Administrator

Date

Citation Number: #10682					ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024			
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024	2024		
	.240					
Rule or Code Section	Natu	re of Violation	Class	Fine Amount	Correction date	

feeling, and didn't think Resident #19 would do anything sexual but touching.		
When queried about touching between Resident #12 and Resident #19, Staff I responded holding hands walking down the hall, further explained she had seen them walk to breakfast, and Resident #19 would walk Resident #12 into the breakfast room. When queried about Resident #12's cognition, Staff I responded 50/50, and explained the resident had insomnia and was sometimes up at night. Per Staff I, Resident #12 wondered where her parents were, and would say here for memory not so good, then would flash back, and thought in [Another State Redacted] at times.		
On 11/18/24 at 10:39 AM, Staff J, CNA queried about Resident #12 and Resident #19. Per Staff J, Resident #19 a very independent guy and did not like getting too much in his space. Staff J described Resident #19's interactions with Resident #12 as normal, and Staff J further explained she felt like Resident #12 got confused when she (Resident #12) looked at Resident #19. Per Staff J, there were times when Resident #12 looked and asked to sit on Resident #19's lap, and Resident #19 said no. Staff J denied seeing any physical interactions between the residents, and said no, he's (Resident #19's) really with it. Per Staff J,		

Page 68 of 97

Facility Administrator

Date

Citation Number: #10682			0	Defe		ber 10, 2024 <mark>ed 2/20/25</mark>
Facility Name Keota Health	e: Care Center				24 – Nov	ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	_ 2024			
Rule or Code Section	Natu	re of Violation	Class	Fine A	Mount	Correction date
	Resident #19 had resp residents.	pect for Resident #12 and other				
	explained Resident #1 and down the halls, a around the afternoon back and forth, would stop walking. Staff J es hard time breathing b and forth, which was all-night thing, and du	Resident #12's cognition, Staff J 2 was anxious, loved to pace up nd loved to sleep. Per Staff J, Resident #12 would start pacing get really anxious, and did not xplained Resident #12 had a ecause resident walked back usually a 4-hour thing or tring the day resident slept all this was normal for the resident.				
	consent process, and and Resident #19. The explained she came to about consent (for Re Director/SW did not a Resident #12's Power Activities Director/SW	AM, the Activities r (SW) queried regarding queried regarding Resident #12 e Activities Director/SW o work one day and was told sident #12), the Activities ctually get a verbal from of Attorney (POA), and the ' was told POA was called and old hands, talk, to sit on his lap,				

Page 69 of 97

Facility Administrator

Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

nothing else. The Activities Director/SW explained this

was communicated via the facility's Director of Nursing (DON). When queried about a documented assessment for Resident #12 regarding consent to

Citation Number: #10682					ber 10, 2024 led 2/20/25
Facility Name: Keota Health Care Center Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		-	Survey Dates: November 4, 2024 – November 19, 2024		
		СР			
	52240				
Rule or Code Section	Nature of Violation		Class	Fine Amount	Correction date
	•	ivity Director/SW explained she ident scored a 6, and other than			

			l
When queried about consent regarding Resident #19, the Activities Director/SW explained it was all told to her (Activities Director/SW) on that same day. When queried about the facility's process for obtaining			
consent, the Activities Director/SW responded she			
was told as long as no touching of private areas it was ok, and it was residents rights. Per the Activities			
Director/SW, she felt had rights to hold hands, and			
nothing more than that. When queried if any staff had			
come to her with concerns, the Activities Director/SW			
denied, explained she even witnessed them talking to			
each other, and other than that nothing sexual going			
on.			
Per the Activities Director/SW, there was an allegation			
that transpired that the DON mentioned when in			
morning meeting, which was when the DON told			
Activities Director/SW she had gotten consent from			
Resident #12's POA and had talked to Resident #19			
about not doing anything inappropriate. When			
queried what the allegation entailed, the Activities			
Director/SW explained was about him putting his			
hand in her shirt. The Activities Director/SW explained			
 there was an incident a couple weeks ago that			
		Page 70 of 9	7

Facility Administrator

Date

Citation Number: #10682					ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024			
Rule or Code Section	Nature of Violation		Class	Fine Amount	Correction date	

On 11/19/24 at 2:43 PM when queried if there was a process of whether or not resident able to give consent on the resident level, the facility's Administrator shook her head. Per the Administrator, went by the BIMS score, and the POA and see what consent they give. The Administrator further explained a situation where maybe the POA would say resident in their own mind and could make their own decisions, and the POA may be able to make consent for the resident to make their own decisions. Review of the Facility Policy titled Abuse Policy, undated, revealed the following: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpartSexual abuse is defined as non-consensual sexual contact of any type with a resident, including sexual harassment, sexual coercion or sexual assault.	Resident #19 did to the Activities Director/SW which she documented and talked to Resident#19 that inappropriate. The Activities Director/SW explained Resident #19 had grabbed the Activities Director/SW's butt.		
	process of whether or not resident able to give consent on the resident level, the facility's Administrator shook her head. Per the Administrator, went by the BIMS score, and the POA and see what consent they give. The Administrator further explained a situation where maybe the POA would say resident in their own mind and could make their own decisions, and the POA may be able to make consent for the resident to make their own decisions. Review of the Facility Policy titled Abuse Policy, undated, revealed the following: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpartSexual abuse is defined as non-consensual sexual contact of any type with a resident, including sexual harassment, sexual coercion		

Page 71 of 97

Facility Administrator

Date

Citation Number: #10682					ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024			
Rule or Code Section	Nature of Violation		Class	Fine Amount	Correction date	

58.43(9)	 481—58.43(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury. 58.43(9) Allegations of dependent adult abuse. Allegations of dependent adult abuse shall be reported and investigated pursuant to Iowa Code chapter 235E and 481—Chapter 52. (I, II, III) DESCRIPTION: 	CLASS II	\$500.00 HELD IN SUSPENSION	UPON RECEIPT
	Based on interview, record review, and facility policy review, the facility failed to ensure all allegations of abuse including allegations of staff to resident rough treatment resulting in fear, resident to resident physical altercations, injuries of unknown origin, and inappropriate touching of a resident's breast and buttocks by another resident, were reported timely to the facility administration for ten of twelve residents reviewed for abuse (Resident #7, Resident #11, Resident #12, Resident #13, Resident #15, Resident #16, Resident #19, Resident #20, Resident #21,			

Facility Administrator

Date

Page 72 of 97

Citation Numb #10682	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР			
Neola, 10wa 32240					
Rule or Code Section	Nature of Violation		Class	Fine Amount	Correction date

Resident #22). The facility reported a census of 26 residents.		
Findings Include:		
1. The Minimum Data Set (MDS), dated 10/09/24, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated moderate cognitive impairment. MDS revealed Resident #20 had delusions, verbal and physical behaviors, and rejection of cares. Resident #20 had impairment of bilateral lower extremities, utilized a wheelchair for mobility, and required substantial to maximal amount of staff assistance to transfer. Diagnoses included non-traumatic brain dysfunction, non-Alzheimer's dementia, heart failure, depression, and psychotic disorder.		
The Care Plan, revised on 9/27/24 revealed Resident #20 had impaired cognitive function evidenced by short- and long-term memory deficits, impaired decision making, and impaired ability to understand others related to a diagnosis of dementia with mood disturbance. The Care Plan identified a risk for chronic pain and revealed Resident #20 had displaced comminuted fracture of the left humeral neck and greater tuberosity with soft tissue swelling on		

Page 73 of 97

Facility Administrator

Date

Citation Number: #10682 Facility Name: Keota Health Care Center Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248 Rule or Code Section					ber 10, 2024 led 2/20/25
		_	Survey Novemb 2024	Dates: per 4, 2024 – Nov	vember 19,
		СР	2024		
		re of Violation	Class	Fine Amount	Correction date
		/24. Intervention instructed staff to apply left lder immobilizer as ordered and as tolerated by ent, for comfort.			
	revealed Resident #20 slight bruising on left	ote, dated 9/25/24 at 5:53 AM,) was found to have swelling and shoulder spread down arm to nable to move arm. Note			

resident, for comfort.		
A Nursing Progress Note, dated 9/25/24 at 5:53 AM, revealed Resident #20 was found to have swelling and slight bruising on left shoulder spread down arm to the elbow, resident unable to move arm. Note informed that nurse reported Resident #20's condition to an on-call Provider and received orders to send resident to the hospital for an evaluation. On 9/25/24 at 8:18 AM, a Nursing Note revealed that Resident #20's Hospice Provider notified the Hospital of resident and family wishes for no treatment and resident sent back to the facility. On 9/25/24 at 8:50 AM, Note informed that Resident #20 had returned to facility with pain rated 8 on a scale of 1 to 10, and charted left arm appeared purple and black around the entire upper arm. At 10:00 AM, facility received an order from Provider for portable x-ray, 2 views, of left shoulder.		
An x-ray report, dated 9/26/24, revealed findings of displaced comminuted fracture of the left humeral neck and greater tuberosity with soft tissue swelling.		
Incident Report for injury of unknown cause, completed on 9/26/24 by Director of Nursing (DON).		

Page 74 of 97

Facility Administrator

Date

Citation Numb	oer:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248			Survey Dates: November 4, 2024 – November 1 2024		
		СР			
Neota, Iowa 5					
Rule or Code Section	Nature of Violation		Class	Fine Amount	Correction date

The Report description of incident revealed Resident	
#20 found by Certified Nursing Assistant (CNA) with	
pain to left shoulder, Nurse assessed resident,	
observed bruising and abnormal range of motion.	
Incident Report identified an injury located on the	
front of left shoulder, unable to identify injury type,	
and immediate action had been to send Resident #20	
to Emergency Room (ER).	
Dovinu of the facility's submitted list of calf reported	
Review of the facility's submitted list of self-reported	
incidents revealed a report had been submitted on	
9/26/24 at 3:22 PM to the State Agency, which listed the incident date as 9/25/24 and incident type as	
accident with major injury.	
Review of the facility's 5-day investigation summary	
for self-reported incident revealed an investigation	
was completed for an unwitnessed incident and	
informed that an incident occurred on 9/25/24 at	
approximately 2:15 PM.	
On 11/19/24 at 12:30 PM, Director of Nursing for	
sister facility, provided assistance with State Survey,	
revealed the expectation for an injury of unknown	
origin to be automatically turned in to State Agency	
and investigated as potential abuse. Sister facility DON	
revealed that the investigation would include a root	

Page 75 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 led 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР			
	2-10				
Rule or Code Section	Nature of Violation		Class	Fine Amount	Correction date

cause analysis, interviews with staff and residents, to try and figure out what happened.		
On 11/19/24 at 2:06 PM, Facility Administrator revealed that Resident #20's injury of unknown origin had been reported to the State Agency after notification had been received from DON that resident had a left shoulder fracture.		
2. Review of the MDS assessment for Resident #19 dated 10/9/24 revealed the resident scored 14 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition.		
The Care Plan for Resident #19 revised 7/13/23 revealed, [Resident #19] has a behavioral management program due to his hx (history) of aggressive behavior towards other residents.		
Review of Resident #19's Care Plan dated 7/4/24 and revised 7/5/24 revealed, [Resident #19] has a Mutual friendship with a resident of the opposite sex. Interventions per Resident #19's Care Plan included the following:		

Page 76 of 97

Facility Administrator

Date

Citation Num #10682	ıber:				ber 10, 2024 led 2/20/25	
Facility Name: Keota Health Care Center Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248				Survey Dates: November 4, 2024 – November 19,		
		СР	2024			
Rule or Code Section	Nature of Violation		Class	Fine Amount	Correction date	
	a. (Initiated 7/5/24, Re or embarrass [Residen relationship.	evised 9/10/24): Do not shame t #19] regarding this				

relationship.		
b. (Initiated 7/5/24, Revised 9/10/24): If [Resident		
#19's] friendship escalates beyond hugging/hand		
holding/sitting together, please redirect in a calm		
manner and we will reassess the plan with staff,		
family and medical advice.		
c. (Initiated 7/5/24, Revised 9/10/24): Mild affection		
(hugging/hand holding/sitting together) is acceptable		
for both families.		
d. (Initiated 10/28/24): POA (Power of Attorney)		
[Name Redacted] verbalizes that hand holding, sitting		
together, female resident sitting this resident's lap,		
and a gentle kiss on the lips is within his scope for		
approval of behavior. He states to please separate		
residents if behaviors become more sexual in nature		
such as touching of one another's private areas. [POA		
name redacted] also requests to be made aware if		
resident's behaviors with female friend appear to		
become inappropriate and not reciprocated.		
e. (Initiated 7/5/24, Revised 9/10/24): Report		
interactions as needed to Charge Nurse.		
f. (Initiated 7/5/24, Revised 9/10/24): This friendship		
is acceptable as long as [Resident #19] is safe and		
happy		
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Page 77 of 97

Facility Administrator

Date

Citation Numbe	r:				ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР				
Rule or Code Section	Code Nature of Violation		Class	Fine Amount	Correction date	

On 11/18/24 at 2:10 PM, Resident #19 observed		
standing up by the nursing station.		
a. Resident #12 and Resident #19:		
Review of the Minimum Data Set (MDS) assessment for Resident #12 dated 9/13/24 revealed the resident scored 5 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident inattention which fluctuated and delusions.		
Review of Medical Diagnoses for Resident #12 included Wernicke's encephalopathy, dementia with psychotic disorder, dementia with mood disturbance, restlessness and agitation, and delusional disorders.		
Review of Resident #12's Care Plan dated 7/7/24 revealed, [Resident #12] has a Mutual friendship with a resident of the opposite sex. Interventions per the Care Plan included the following:		
 a. (Created 7/7/24, revised 9/10/24): Do not shame or embarrass [Resident #12] for her friendship. b. (Created 7/7/24, revised 9/10/24): If [Resident #12's] friendship escalates beyond hugging/hand holding/sitting together, please redirect in a calm 		

Page 78 of 97

Facility Administrator

Date

Citation Number: #10682					ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024	_ 2024		
	.240					
Rule or Code Nature Section		ure of Violation	Class	Fine Amount	Correction date	

manner and we will re-assess the plan with staff,		
family and medical advice.		
c. (Created 7/7/24, revised 9/10/24): Mild affection		
(hugging/hand holding/sitting together) is acceptable		
for both families.		
d. (Created 10/28/24): Per POA: hand holding, sitting		
together, resident sitting on other male resident's lap,		
and a gentle kiss on the lips is within her scope for		
approval of behavior. Please separate residents if		
behaviors become more sexual in nature such as		
touching of one another's private areas		
e. (Created 7/7/24, revised 9/10/24): Report		
interactions as needed to Charge Nurse.		
f. (Created 7/7/24, revised 9/10/24): This friendship is		
acceptable if [Resident #12] is safe and happy.		
The Nursing Note for Resident #12 dated 10/26/24 at		
5:56 PM revealed, CNA (Certified Nursing Assistant)		
reports to this nurse that at around 1555 (3:55 PM) a		
male resd reached up this resd (resident) shirt et		
groped her It (left) breast while she was standing next		
to him. These 2 resd are care planned to have a		
friendly relationship that involve holding hands et		
hugging. This nurse witnessed female resd approach		
male resd seated in lobby, they proceeded to hold		
hands before this nurse had left to attend another		
resd. CNA separated the 2 resd. CNA reports that resd		
was asking where male resd went? CNA redirected et		

Page **79** of **97**

Facility Administrator

Date

Citation Numb	er:	Date: December Amended 2			ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024		
Reola, Iowa 52240					
Rule or Code Section	Code Nature of Violation		Class	Fine Amount	Correction date

kept them apart. When female resd asked by this nurse if the male resd had touched her breast she states "No." Administrator made aware. Called x2 numbers for POA (Power of Attorney) with no answer et (and) left message.		
The Nursing Note for Resident #19 dated 10/26/24 at 5:43 PM revealed, CNA reports to this nurse that at around 1555 (3:55 pm) this resd reached up a female resd shirt et groped her It breast while she was standing next to him. These 2 resd are care planned to have a friendly relationship that involve holding hands et hugging. This nurse witnessed female resd approach male resd seated in lobby, they proceeded to hold hands before this nurse had left to attend another resd. No other resd in lobby witnessed event when asked. [Resident #19] was confronted and asked if anything happened when female resd approached him? resd states "No." when asked if they were holding hands? He states "yeah we were holding hands." Resd was asked if he touched female resd anywhere else? states "her back side a little." Resd asked if he reached up female resd shirt? States "no." Administrator made aware. POA [POA Name		
Redacted] made aware. On 11/13/24 at 12:06 PM, Resident #12 observed in her room in bed. On 11/18/24 at 2:10 PM, Resident		

Page 80 of 97

Facility Administrator

Date

Citation Numb	er:	Date: December 10 Amended 2/2			•	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024	- 2024		
Rule or Code Section	Nature of Violation		Class	Fine Amount	Correction date	

 -		
#12 observed standing up by the nurses' station near the lobby area of the facility.		
Review of the self-report list emailed by the Administrator on 11/4/24 lacked the alleged incident between Resident #12 and Resident #19 which occurred 10/26/24.		
Review of an updated self-report list emailed by the facility's Administrator on 11/13/24 lacked the alleged incident between Resident #12 and Resident #19 on 10/26/24.		
On 11/14/24 at 1:56 PM, the Administrator responded Resident #19 and Resident #12 were friends, the Administrator explained had heard holding hands came to light. The Administrator acknowledged not aware of touching of the resident's breast and butt. Per the Administrator, if unaware of touching of the resident's breast, then could not report.		
On 11/19/24 at 2:44 PM. the Administrator explained, in part, she had received a text message over the weekend; Staff D, Licensed Practical Nurse (LPN) did the investigation, and was told one thing versus what the CNA said. When queried more about the text message, the Administrator explained she had		

Page 81 of 97

Facility Administrator

Date

Citation Numb	per:				ber 10, 2024 led 2/20/25	
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 2024		24 – November 19,	
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024	_ 2024		
Rule or Code Nature of Violation Section		ture of Violation	Class	Fine Amount	Correction date	

	received a voicemail, and acknowledged she listened to the voicemail maybe a couple of days ago. When queried about the voicemail, the Administrator			
	explained said there's an allegation of CNA saying			
	Resident #19 put hand up Resident #12's shirt and			
	touched breast. Per the Administrator, the voicemail			
	was from Staff D, Licensed Practical Nurse.			
	b. Resident #15 and Resident #19:			
	Review of the Minimum Data Set (MDS) assessment			
	for Resident #15 dated revealed the resident scored			
	00 out of 15 on a Brief Interview for Mental Status			
	(BIMS) exam, which indicated severely impaired			
	cognition.			
	Review of the Care Plan for Resident #15 dated			
	2/22/24, revised on 3/17/24, revealed, [Resident #15]			
	has episodes of behaviors as evidenced by: being			
	combative grabbing slapping pulling away hitting			
	negative verbalizations name calling refusal of			
	medications/ cares resists cares tries to leave facility			
	crying episodes screaming out hallucinations/			
	delusions. Interventions per Resident #15's Care Plan included, in part, the following:			
	a. Observe for early warning signs of oncoming			
	behaviors- Approach in a call manner, call by name,			
	remove			
L		II	Page 82	of O
			Page 82	01.91

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР	2024		
Keota, Iowa 52248					
Rule or Code Nature of Viola Section		re of Violation	Class	Fine Amount	Correction date

b. Minimize the potential for the resident's disruptive		
behaviors by offering tasks which divert attention.		
The Incident Note for Resident #15 dated 8/18/24 at 11:46 AM revealed, in part, [Resident #15] has been pacing in w/c (wheelchair) this morning, at 1015 this nurse witnessed [Resident #15] run over male resd root in w/c, male resd seated in large recliner in lobby hit [Resident #15] across back with both arms et (and) fists. Male resd asked to go to room in order to separate the two residents. No redness or bruising noted to back, when asked if having pain states "yes." DON (Director of Nursing) et administrator notified at 1022.		
The Incident Note for Resident #19 dated 8/18/24 at 11:15 AM revealed, at 1015 this nurse witnessed [Resident #19] seated in large recliner in lobby whack female resd across back with both arms et fists, female resd in w/c pacing et ran over [Resident #19's] foot. Resd wearing sneakers. Spoke with [Resident #19], informed that this female resd is not doing it intentionally, resd states "I know." Discussed with [Resident #19] that there are other ways to handle a situation. [Resident #19] asked to go to his room in order to separate the two residents. Resd in bed, reports that It (left) foot was ran over, when assessed		

Page 83 of 97

Facility Administrator

Date

Citation Numb	er:	Date: December 1 Amended 2			ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР			
Keota, Iowa 52248					
Rule or Code Section	Code Nature of Violation		Class	Fine Amount	Correction date

no bruising, swelling or redness. Resd reports he is still having pain to lt foot 5/10.		
The Nursing Note for Resident #15 dated 8/19/24 at 5:52 AM revealed, CNA [Name Redacted, Staff I] reports 2		
red marks on resident's low back from incident on 9/18/24.		
Although the incident between Resident #15 and		
Resident #19 was documented in both resident records on 8/18/24, review of the facility's list of		
self-reported incidents revealed an Allegation of		
Abuse was reported between Resident #15 and		
Resident #19 for an incident date 8/19/24.		
Observation on 11/06/24 at 9:26 AM revealed		
Resident #15 up and ambulatory at the facility.		
On 11/4/24 at 11:26 a.m., Resident #19 sat in a chair		
in the main dining room and ate lunch. The State		
Agency (SA) made multiple attempts throughout the		
survey to speak with him with no success.		
On 11/14/24 at approximately 1:00 p.m., the		
Administrator stated the incident with Residents #15		
and #19 occurred on 9/19/24 and she reported it on 9/20/24.		

Page 84 of 97

Facility Administrator

Date

Citation Numb #10682	er:	Date: December Amended 2			ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР	2024	- 2024		
Keota, Iowa 52248						
Rule or Code Natur Section		re of Violation	Class	Fine Amount	Correction date	

3. The Minimum Data Set (MDS) assessment tool,		
dated 6/21/24, listed diagnoses for Resident #22		
which included diabetes, arthritis, and hip fracture.		
The MDS listed the resident's Brief Interview for		
Mental Status (BIMS) score as 1 out of 15, indicating		
severely impaired cognition. The MDS stated the		
resident had the following:		
a. physical behavioral symptoms directed towards		
others (e.g., hitting, kicking, pushing, scratching,		
grabbing, abusing others sexually) which occurred 1-3		
days out of the 7-day review period.		
b. verbal behavioral symptoms directed towards		
others (e.g., threatening others, screaming at others,		
cursing at others) which occurred 4-6 days out of the		
7-day review period.		
c. other behavioral symptoms not directed towards		
others (e.g., physical symptoms such as hitting or		
scratching self, pacing, rummaging, public sexual acts,		
disrobing in public, throwing or smearing food or		
bodily wastes, or verbal/vocal symptoms like		
screaming, disruptive sounds) which occurred 1-3		
days out of the 7-day review period.		
A 6/21/24 Care Plan entry directed staff to intervene		
as necessary to protect the rights and safety of the		
other residents, divert attention, remove from the		

Page 85 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР			
Neola, Iowa 52240					
Rule or Code Nature of Violation Section		e of Violation	Class	Fine Amount	Correction date

situation/location if needed, and approach/speak in a calm manner.			
An 8/22/24 Care Plan entry directed staff to redirect the resident when she became notably agitated and to monitor her when she was around others.			
An 8/26/24 Care Plan intervention directed staff to monitor the resident when she was in the hallways to ensure safe interactions with other residents. The entry directed staff to remove her from other residents and intervene when she headed toward other residents.			
An 8/28/24 Care Plan entry stated the physician made medication changes as an intervention to behaviors and resident to resident interactions.			
A 9/30/24 Care Plan entry directed staff to place the resident in an area where not within an arm's length of other residents.			
A Care Plan entry, revised 10/21/24, stated the resident had episodes of behaviors/potential for behaviors as evidenced by combativeness, negative verbalizations, name calling, screaming out, throwing things at staff, cursing at staff and other residents,			
c Att Areerc Are Arc Arkst	calm manner. An 8/22/24 Care Plan entry directed staff to redirect the resident when she became notably agitated and o monitor her when she was around others. An 8/26/24 Care Plan intervention directed staff to monitor the resident when she was in the hallways to ensure safe interactions with other residents. The entry directed staff to remove her from other residents and intervene when she headed toward other residents. An 8/28/24 Care Plan entry stated the physician made medication changes as an intervention to behaviors and resident to resident interactions. A 9/30/24 Care Plan entry directed staff to place the resident in an area where not within an arm's length of other residents. A Care Plan entry, revised 10/21/24, stated the resident had episodes of behaviors/potential for behaviors as evidenced by combativeness, negative verbalizations, name calling, screaming out, throwing	An 8/22/24 Care Plan entry directed staff to redirect the resident when she became notably agitated and o monitor her when she was around others. An 8/26/24 Care Plan intervention directed staff to nonitor the resident when she was in the hallways to ensure safe interactions with other residents. The entry directed staff to remove her from other residents and intervene when she headed toward other residents. An 8/28/24 Care Plan entry stated the physician made medication changes as an intervention to behaviors and resident to resident interactions. A 9/30/24 Care Plan entry directed staff to place the resident in an area where not within an arm's length of other residents. A Care Plan entry, revised 10/21/24, stated the resident had episodes of behaviors/potential for behaviors as evidenced by combativeness, negative verbalizations, name calling, screaming out, throwing hings at staff, cursing at staff and other residents,	 an manner. An 8/22/24 Care Plan entry directed staff to redirect the resident when she became notably agitated and o monitor her when she was around others. An 8/26/24 Care Plan intervention directed staff to monitor the resident when she was in the hallways to ensure safe interactions with other residents. The entry directed staff to remove her from other residents and intervene when she headed toward other residents. An 8/28/24 Care Plan entry stated the physician made medication changes as an intervention to behaviors and resident to resident interactions. A 9/30/24 Care Plan entry directed staff to place the esident in an area where not within an arm's length of other residents. A Care Plan entry, revised 10/21/24, stated the esident had episodes of behaviors/potential for behaviors as evidenced by combativeness, negative verbalizations, name calling, screaming out, throwing hings at staff, cursing at staff and other residents,

Page 86 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 led 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР	- 2024		
Keota, Iowa 52248					
Rule or Code Nature of Violation Section		re of Violation	Class	Fine Amount	Correction date

cussing at staff and other residents, flipping staff off with middle finger, yelling, as well as other aggressive		
behaviors. The resident had the following incidents:		
On $8/22/24$, the resident hit another resident.		
On 8/26/24, the resident grabbed and scratched		
another resident.		
On 9/6/24, the resident slapped another resident.		
On 9/30/24, the resident slapped and pinched		
another resident while she called them names.		
On 10/20/24, the resident grabbed the arm of		
another resident.		
a. Resident #22 and Resident #13		
The MDS assessment tool, dated 8/21/24, listed		
diagnoses for Resident #13 which included		
non-Alzheimer's dementia, depression, and psychotic		
disorder. The MDS listed the resident's BIMS score as		
4 out of 15, indicating severely impaired cognition.		
A 9/30/24 Physical Aggression Initiated report hit and		
pinched another resident. The other resident also hit		
Resident #22.		
A 9/30/24 Nursing Note stated the resident sat in the		
lobby next to another resident and started hitting and		
pinching her. The other resident also hit and pinched.		

Page 87 of 97

Facility Administrator

Date

Citation Number: #10682 Facility Name: Keota Health Care Center Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248 Rule or Code Natur Section		82 lity Name:		Date: December 10, 20 Amended 2/20/2 Survey Dates: November 4, 2024 – November 19		
		СР	2024			
		re of Violation	Class	Fine Amount		Correction date
	9/30/24 incident to the On 11/14/24 at approx Administrator stated th #22 and Resident #13 informed of it on 10/1, b. Resident #22 and Re The MDS assessment th diagnoses for Resident Parkinson's (a disease tremors), and depressing resident's BIMS score of severely impaired cogn A 10/20/24 Verbal Agg another resident yelled	he incident between Resident occurred on 9/30/24. She was /24 and reported it on 10/2/24. esident #21 ool, dated 9/13/24, listed #21 which included diabetes, which causes symptoms such as on. The MDS listed the of 0 out of 15, indicating				

A 10/20/24 Incident Note stated a resident grabbed Resident #21's arm when Resident #21 asked her not to tap the couch.

The facility lacked documentation they reported the 10/20/24 incident to the State Agency.

Page 88 of 97

Facility Administrator

Date

Citation Numb #10682	er:	Date: December 10 Amended 2/2			
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР			
Keota, Iowa 52248					
Rule or Code Nature of Viola Section		e of Violation	Class	Fine Amount	Correction date

4a. The MDS assessment tool, dated 10/23/24, listed diagnoses for Resident #7 which included diabetes, non-Alzheimer's dementia, and anxiety disorder. The MDS stated the resident's BIMS score was 1 out of 15, indicating severely impaired cognition.		
A 6/20/19 Care Plan entry stated the resident was independent with transfers.		
b. The MDS assessment tool, dated 8/28/24, listed diagnoses for Resident #11 which included non-Alzheimer's dementia, anxiety, and psychotic disorder. The MDS stated the resident required partial to moderate assistance for walking and listed a BIMS score of 0 out of 15, indicating severely impaired cognition.		
A 2/24/24 Care Plan entry stated the resident required the assistance of 1 staff for short and long-distance walking as the resident allowed.		
c. The MDS assessment tool, dated 9/11/24, listed diagnoses for Resident #15 which included Alzheimer's disease, non-Alzheimer's dementia, and anxiety disorder. The MDS stated the resident walked independently and listed the resident's BIMS score as 0 out of 15, indicating severely impaired cognition.		

Page 89 of 97

Facility Administrator

Date

Citation Numb	er:	Date: December Amended			ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024	- 2024		
Rule or Code Nature o Section		re of Violation	Class	Fine Amount	Correction date	

A 2/22/24 Care Plan entry stated the resident walked independently.		
d. The MDS assessment tool, dated 9/20/24, listed diagnoses for Resident #16 which included Alzheimer's, non-Alzheimer's dementia, and depression. The MDS stated the resident walked independently and listed her BIMS score as 0 out of 15, indicating severely impaired cognition.		
A 7/7/21 Care Plan entry stated the resident walked independently.		
On 11/7/24 at 1:28 p.m., via phone, Staff E Registered Nurse (RN) stated there were a couple staff members, Staff O Certified Nursing Assistant (CNA) and Staff P CNA who were a "little rough" with the residents when walking down the hall. She stated they pulled them instead of walking with them and said "come on". She stated they pulled them with both of their hands and do this with Residents #7, #11, #15, and #16. She stated it was unsafe and the residents were scared and "shaking". She stated she reported this to the Business Office Manager.		

Page 90 of 97

Facility Administrator

Date

Citation Numb	er:	Date: December ² Amended 2			ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР			
Neula, IUwa 32240					
Rule or Code Nature of Violatic Section		e of Violation	Class	Fine Amount	Correction date

The facility lacked documentation they reported the above allegations of abuse and lacked documentation they separated residents from Staff O and Staff P during the investigation.		
On 11/7/24 at 2:04 p.m., the Administrator stated she wanted residents treated with respect, compassion and kindness. She stated Staff O and Staff P were both kind and no staff reported any concerns to her about them.		
On 11/12/24 at 12:00 p.m., via phone Staff E stated she spoke to the Administrator about staff walking with staff in an unsafe manner and stated the Administrator told her she didn't like how they pulled people but she was "stuck between a rock and a hard place".		
On 11/12/24 at 1:06 p.m., Staff G RN stated staff pulled residents by the arms while they walked them. She stated they were not abusive but rushed and rude.		
On 11/19/24 at 11:59 a.m. via phone, the Director of Nursing (DON) of a sister facility stated staff should report allegations of abuse to the DON and then the Administrator and they would investigate and report. She stated the staff in question would be suspended.		

Page 91 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 ed 2/20/25
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР	- 2024		
Keota, Iowa 52248					
Rule or Code Nature of Violation Section		e of Violation	Class	Fine Amount	Correction date

	The facility policy "Abuse Reporting and Investigation" revised 11/28/16, stated the facility would thoroughly investigate all reports of suspected or alleged abuse and stated if an employee is involved in the suspected violation, they would be immediately removed from duty for the duration of the investigation. The undated facility "Abuse Policy" stated the facility would report incidents of suspected abuse to the SA immediately but not later than 2 hours. On 11/14/24 at approximately 1:00 p.m., the Administrator stated it was her understanding that allegations of abuse be reported within 24 hours.			
58.24(5)C	481—58.24(135C) Dietary. 58.24(5) Food handling, preparation and service. All food shall be handled, prepared and served in compliance with the requirements of the Food and Drug Administration Food Code adopted under provisions of Iowa Code section 137F.2. (I, II, III) In addition, the following shall apply. c. Foods shall be cut up, chopped, ground or blended to meet individual needs. (I, II, III)	Class I	\$4,000.00 HELD IN SUSPENSION	UPON RECEIPT

Page 92 of 97

Facility Administrator

Date

Citation Numb	er:	Date: December 10, Amended 2/20			•
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР	- 2024		
Keota, Iowa 52248					
Rule or Code Nature Section		re of Violation	Class	Fine Amount	Correction date

DESCRIPTION:		
Based on observation, clinical record review, policy review, and staff interview, the facility failed to provide the correct diet for 2 of 5 residents reviewed for nutrition (Residents #11 and #226). The facility reported a census of 26 residents.		
Findings include:		
1. The Care Plan, dated 10/31/24, revealed that Resident #226 has nutritional problem or potential for nutritional problem and required regular diet with pureed texture, and instructed staff to serve diet as ordered.		
Resident #226 diet order, dated 10/31/24, revealed order for regular, puree texture diet and thin liquids.		
Review of Nutritional Assessment, dated 11/04/24, informed that Resident #226 is at increased risk for altered nutrition due to co-morbidities, chewing and swallowing difficulty, and modified texture.		
The Discharge Summary from previous nursing home, dated 10/31/24, stated that resident needed		

Page 93 of 97

Facility Administrator

Date

Citation Numb	er:	Date: December 10, Amended 2/20			•
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР			
Neola, Iowa 52240					
Rule or Code Nature of Violation Section		Class	Fine Amount	Correction date	

supervision with eating and that resident should be		
served one food at a time with a small spoon.		
On 11/04/24 at 11:20 a.m., Staff A, Cook served		
Resident #226 a plate of regular consistency food.		
One minute later, staff A, cook came back and stated		
that he knew he was going to screw that up and		
proceeded to take the food away from Resident #226		
after he had consumed several bites of food. At that		
time the resident had began excessively coughing		
with large amount of phlegm coming from mouth and		
nose.		
On 11/04/24 at 11:22 a.m., Resident #226 stopped		
coughing and drooling.		
On 11/04/24 at 11:24 a.m., Resident #226 was served		
the correct consistency and proceeded to cough with		
eating intermittently, but was able to eat some more		
food of the pureed consistency.		
On 11/04/24 at 11:30 a.m., the Director of Nursing		
(DON) was interviewed on what Resident#226 's diet		
is ordered as and she stated that it is puree texture		
with thin liquids and handle cups. She stated that she		
provided it to the kitchen herself prior to the resident		
's arrival. She was then queried on what would		
happen if Resident #226 would be provided with		

Page 94 of 97

Facility Administrator

Date

Citation Numb #10682	er:	Date: December 10, 2 Amended 2/20/			
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – November 19, 2024		ember 19,
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР			
Keota, Iowa 52248					
Rule or Code Nature of Section		e of Violation	Class	Fine Amount	Correction date

regular consistency food and she stated that he would most likely choke because he eats his food very fast. At this point in time, the State Agency (SA) notified the DON of the findings to allow for appropriate assessment and interventions for this resident.		
On 11/04/24 at 11:38 a.m., interview from Staff A, Cook, revealed that the dietary staff get the dietary information from the nurses. Staff A, cook, acknowledged that he provided the resident with regular consistency food and then noticed that his count was off for plates so he and went back to fix it. Staff A, cook, acknowledged that Resident #226 would probably choke if he ate regular consistency food. When queried about the location of the modified diet postings in the kitchen, staff A, cook stated that it is posted in the kitchen and that it is also in a book. Staff A, Cook, stated that he does not utilize the books because he has struggled with them.		
On 11/04/24 at 11:48 a.m., Resident #226 was found lying in his room alone. The Resident stated that he was fine and he did not feel short of breath. At that time, the resident was noted to still have an intermittent cough. The resident denied feeling like there was anything stuck in his throat		

Page 95 of 97

Facility Administrator

Date

Citation Numb	er:				ber 10, 2024 ed 2/20/25	
Facility Name: Keota Health Care Center			Novemb	Survey Dates: November 4, 2024 – November 19, 2024		
Facility Address/City/State/Zip 204 N Keokuk Washington Rd		СР	2024	_ 2024		
Keota, Iowa 52248						
Rule or Code Natur Section		ure of Violation	Class	Fine Amount	Correction date	

2. The Minimum Data Set (MDS) assessment tool, dated 8/28/24, listed diagnoses for Resident #11 which included non-Alzheimer's dementia, anxiety, and psychotic disorder. The MDS listed a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating severely impaired cognition.		
On 11/6/24 at 11:23 a.m., Resident #11 ate cole slaw which contained shredded cabbage approximately a half inch long.		
An Order Details report listed a 5/30/24 order for a mechanical soft ground meat diet texture.		
The Week 1 Wednesday Menu directed staff to serve residents on a regular diet creamy coleslaw and residents on a mechanical soft diet steamed cabbage.		
On 11/6/24 at 12:42 p.m., the Certified Dietary Manager (CDM) stated she served Resident #11 cole slaw because she did not have extra cabbage (to boil). She stated she cut it down to a smaller size for her to eat.		
On 11/19/24 at 11:59 a.m. via phone, the Director of Nursing (DON) of a sister facility stated the facility should follow diet orders.		

Page 96 of 97

Facility Administrator

Date

Citation Numb	per:				ber 10, 2024 led 2/20/25	
Facility Name: Keota Health Care Center			Survey Dates: November 4, 2024 – Nover 2024		vember 19,	
Facility Address/City/State/Zip 204 N Keokuk Washington Rd Keota, Iowa 52248		СР	2024	_ 2024		
Rule or Code Natu Section		ure of Violation	Class	Fine Amount	Correction date	

The facility policy "Therapeutic Diets", revised October 2017, stated diets would be determined in accordance with the resident's treatment goals and would include modifications in texture.		
FACILITY RESPONSE:		

Page 97 of 97

Facility Administrator

Date