STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. BUILDING _____ B. WING _____	C 06/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: _____ The following deficiencies resulted from investigation of Complaints #111031-C, #109479-C and Facility Reported Incidents #111490-I and #112842-I conducted on June 12, 2023 to June 15, 2023. Complaint #111031-C-C was substantiated. Facility Reported Incident #112842-I was substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure residents are free from abuse for one of one reviewed residents.	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/26/2023

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F 600	Continued From page 1	F 600		

(Resident #1) The facility reported census is 30.

Findings include:

According to a Quarterly Minimum Data Set (MDS) with a reference date of 3/23/23, Resident #1 had short and long term memory deficits and a severely impaired cognitive status. Resident #1 was independent with transfers and mobility, but required extensive assistance with dressing, toilet use and personal hygiene needs. Resident #1's diagnosis included Alzheimer's Disease, Non-Alzheimer's dementia, renal insufficiency and seizure disorder.

According to a Quarterly Minimum Data Set (MDS) with a reference date of 4/4/23, Resident #2 had a Brief Mental Status (BIMS) score of 10 indicating a moderately impaired cognitive status. Resident #2 required limited assistance with transfers and mobility and extensive assistance with dressing, toilet use and personal hygiene needs. Resident #2's diagnosis included schizophrenia, Non-Alzheimer's dementia, diabetes mellitus and cerebral vascular accident (stroke).

According to Resident #2's plan of care, he had a problem with being sexually inappropriate verbally and physically with another female resident. Interventions included to intervene as necessary to protect the rights and safety of others, to use a door alarm with his door closed to alert staff when resident was exiting room and to provide 1:1 supervision of resident when he is out of his room.

In an interview on 6/12/23 at 2:40 p.m. Staff A, Housekeeper, stated on 4/29/23 she heard

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F 600	Continued From page 2	F 600		

Resident #2's door alarm sound and she proceeded to his room. Resident #2 was putting on his jacket and stating he was going to the lobby. Staff A shut off the alarm. Staff B, Certified Nurses Aide (CNA) was also present and aware Resident #2 was going to leave his room. Staff A assumed Staff B would provide Resident #2 supervision per his plan of care. Staff A stated she left and went to the sun room where she got a soda. Within minutes she returned and noticed Resident #2's door closed. Staff A looked in to find Resident #1 sitting in a chair with her shirt pulled up and Resident # 2 with his hands cupped over Resident #1's breast and his mouth over her breast, sucking on it. Staff A stated she attempted to separate the two, but Resident #2 was resistive, refusing to let go of Resident #1. Staff A called out for assistance and Resident #1 and Resident #2 were separated. Staff A stated the reason for alarming Resident #2's door and providing supervision was because of another similar incident in which Resident #2 was sexually inappropriate with another female resident. Resident #1 was moved to another hall after the incident with Resident #2.

In an interview on 6/14/23 at 10:21 a.m. Staff B, CNA, stated on 4/29/23 she and Housekeeper Staff A were walking down East hall. Resident #2 was putting on his jacket and exiting his room. Staff B stated she told Staff A she was going to the North hall to answer a call light and assumed Staff A would remain and provide supervision of Resident #2. Staff B stated when she returned to East hall, Staff A told her what had happened between Resident #2 and Resident #1.

According to the facilities root cause analysis, both Staff A and Staff B thought the other person

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F 600	Continued From page 3 was going to stay and supervise Resident #2 and neither did, leaving an opportunity for Resident #2 to sexually abuse Resident #1. According to an Interdisciplinary Team (IDT) note dated 5/1/23 at 10:04 a.m. The Director of Nursing (DON), wrote Resident #1 wanders aimlessly stating illogical comments or fragmented sentences. Resident #1 will signal by saying No or striking out when she doesn't want cares or the direction she is lead. On the date Resident #1 wandered into Resident #2's room and was touched inappropriately, she showed no signs of discomfort or distress.	F 600		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to ensure residents receive adequate services (bathing) to maintain their personal hygiene needs for 1 of 2 residents sampled. Review of bathing records May 2023 through June 15, 2023 found bathing opportunities were provided twice weekly as scheduled, however one resident refused all but once during that time period. The facility failed to address the resident's refusals leading to personal hygiene needs being unmet. (Resident #4) The facility reported census was 30. Findings include:	F 677		

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F 677	Continued From page 4 According to a Quarterly Minimum Data Set (MDS) with a reference date of 5/24/23, Resident #4 had a Brief Mental Status (BIMS) score of 8 which indicated a moderately impaired cognitive status. Resident #4 required limited assistance with transfers, mobility, dressing, toilet use and personal hygiene needs. Resident #4's diagnosis included Non-Alzheimer's dementia and diabetes mellitus. According to Resident #4's bathing records, she was scheduled to have baths on Wednesdays and Saturdays. Review of shower records from May 3, 2023 through June 14, 2023 noted Resident #4 with 13 opportunities to bath. Resident #4 refused bathing 12 of those opportunities leaving her only one bath in the last 45 days. Review of the Care Plan found Resident #4 sometimes refused showers with interventions to offer a diet soda or a rice crispy treat to motivate her to bath. Review of progress notes finds no entries in which these interventions are offered.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 689		

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F 689	Continued From page 5	F 689		

facility failed to provide adequate supervision of a resident to prevent inappropriate sexual contact with other female residents. (Resident #2) The facility reported census is 30.

Findings include:

According to a Minimum Data Set (MDS) with a reference date of 3/23/23, Resident #1 had short and long term memory deficits and a severely impaired cognitive status. Resident #1 was independent with transfers and mobility, but required extensive assistance with dressing, toilet use and personal hygiene needs. Resident #1's diagnosis included Alzheimer's Disease, Non-Alzheimer's dementia, renal insufficiency and seizure disorder.

According to a Minimum Data Set (MDS) with a reference date of 4/4/23, Resident #2 had a Brief Mental Status (BIMS) score of 10 indicating a moderately impaired cognitive status. Resident #2 required limited assistance with transfers and mobility and extensive assistance with dressing, toilet use and personal hygiene needs. Resident #2's diagnosis included schizophrenia, Non-Alzheimer's dementia, diabetes mellitus and cerebral vascular accident (stroke).

According to Resident #2's plan of care, he had a problem with being sexually inappropriate verbally and physically with another female resident. Interventions included to intervene as necessary to protect the rights and safety of others, to use a door alarm with his door closed to alert staff when resident was exiting room and to provide 1:1 supervision of resident when he is out of his room.

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F 689	Continued From page 6	F 689		

In an interview on 6/12/23 at 2:40 p.m. Staff A, housekeeper, stated on 4/29/23 she heard Resident #2's door alarm sound and she proceeded to his room. Resident #2 was putting on his jacket and stating he was going to the lobby. Staff A shut off the alarm. Staff B, CNA was also present and aware Resident #2 was going to leave his room. Staff A assumed Staff B would provide Resident #2 supervision per his plan of care. Staff A stated she left and went to the sun room where she got a soda. Within minutes she returned and noticed Resident #2's door closed. Staff A looked in to find Resident #1 sitting in a chair with her shirt pulled up and Resident # 2 with his hands cupped over Resident #1's breast and his mouth over her breast, sucking on it. Staff A stated she attempted to separate the two, but Resident #2 was resistive, refusing to let go of Resident #1. Staff A called out for assistance and Resident #1 and Resident #2 were separated. Staff A stated the reason for alarming Resident #2's door and providing supervision was because of another similar incident in which Resident #2 was sexually inappropriate with another female resident. Resident #1 was moved to another hall after the incident with Resident #2.

In an interview on 6/14/23 at 10:21 a.m. Staff B, certified nurse aide, stated on 4/29/23 she and housekeeper Staff A were walking down East hall. Resident #2 was putting on his jacket and exiting his room. Staff B stated she told Staff A she was going to the North hall to answer a call light and assumed Staff A would remain and provide supervision of Resident #2. Staff B stated when she returned to East hall, Staff A told her what had happened between Resident #2 and Resident #1.

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F 689	Continued From page 7 According to the facilities root cause analysis, both Staff A and Staff B thought the other person was going to stay and supervise Resident #2 and neither did, leaving an opportunity for Resident #2 to sexually abuse Resident #1. According to an interdisciplinary team (IDT) note dated 5/1/23 at 10:04 a.m. The Director of Nursing (DON), wrote Resident #1 wanders aimlessly stating illogical comments or fragmented sentences. Resident #1 will signal by saying No or striking out when she doesn't want cares or the direction she is lead. On the date Resident #1 wandered into Resident #2's room and was touched inappropriately, she should no signs of discomfort or distress.	F 689		