PRINTED: 06/26/2023 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		165355	B. WING		06	C / 15/2023	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 204 NORTH KEOKUK WASHINGTON ROA KEOTA, IA 52248	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS Correction date: The following deficie		F 00	00			
	investigation of Com #109479-C and Faci #111490-I and #1128 2023 to June 15, 202	plaints #111031-C, lity Reported Incidents 342-I conducted on June 12, 23.					
	Facility Reported Incomposition Substantiated. See code of Federal	C-C was substantiated. ident #112842-I was Regulations (42 CFR), Part					
F 600 SS=D	483, Subpart B-C. Free from Abuse and CFR(s): 483.12(a)(1)	•	F 60	00			
	Exploitation The resident has the neglect, misappropriand exploitation as dincludes but is not lir corporal punishment	om Abuse, Neglect, and right to be free from abuse, ation of resident property, lefined in this subpart. This mited to freedom from i, involuntary seclusion and inical restraint not required to medical symptoms.					
	§483.12(a) The facili	ity must-					
	physical abuse, corp involuntary seclusion This REQUIREMEN by: Based on record rev	n; T is not met as evidenced view and staff interviews, the re residents are free from					
AROPATORY	NIDECTOR'S OR DROVINER	/SLIPPLIER REPRESENTATIVE'S SIGNATUR	 DE	TITI F		(X6) DATE	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

06/26/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED C			
		165355	B. WING		06	6/15/2023		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248		1 00/10/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 600	Findings include: According to a Qual (MDS) with a refere #1 had short and lot severely impaired cowas independent with required extensive a use and personal hydiagnosis included A Non-Alzheimer's de and seizure disorde According to a Qual (MDS) with a refere #2 had a Brief Mentindicating a modera Resident #2 require transfers and mobili with dressing, toilet needs. Resident #2 schizophrenia, Nondiabetes mellitus an (stroke).	rterly Minimum Data Set nce date of 3/23/23, Resident ng term memory deficits and a ognitive status. Resident #1 ith transfers and mobility, but assistance with dressing, toilet ygiene needs. Resident #1's Alzheimer's Disease, mentia, renal insufficiency er. rterly Minimum Data Set nce date of 4/4/23, Resident tal Status (BIMS) score of 10 itely impaired cognitive status. It and extensive assistance with ity and extensive assistance use and personal hygiene 2's diagnosis included Alzheimer's dementia, and cerebral vascular accident ent #2's plan of care, he had a	F 60	0				
	and physically with Interventions includ to protect the rights door alarm with his resident was exiting supervision of resideroom. In an interview on 6	sexually inappropriate verbally another female resident. ed to intervene as necessary and safety of others, to use a door closed to alert staff when proom and to provide 1:1 ent when he is out of his //12/23 at 2:40 p.m. Staff A, d on 4/29/23 she heard						

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		165355	B. WING		,	C 06/15/2023	
NAME OF PROVIDER OR SUPPLIER KEOTA HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248		DE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 600	on his jacket and stat lobby. Staff A shut of Nurses Aide (CNA) we Resident #2 was goir assumed Staff B wou supervision per his place left and went to the a soda. Within minut Resident #2's door of find Resident #1 sitting pulled up and Resident #1's big breast, sucking on it. attempted to separate was resistive, refusing Staff A called out for and Resident #2 were the reason for alarming providing supervisions similar incident in which inappropriate with an Resident #1 was movincident with Resident #2 Staff A would remain Resident #2. Staff B East hall, Staff A told between Resident #2 According to the facility.	arm sound and she m. Resident #2 was putting ing he was going to the if the alarm. Staff B, Certified was also present and aware ng to leave his room. Staff A ald provide Resident #2 an of care. Staff A stated he sun room where she got es she returned and noticed osed. Staff A looked in to ng in a chair with her shirt on # 2 with his hands cupped reast and his mouth over her Staff A stated she the two, but Resident #2 g to let go of Resident #1 assistance and Resident #2 g to let go of another ich Resident #2 was sexually other female resident. Wed to another hall after the at #2. 4/23 at 10:21 a.m. Staff B, 23 she and Housekeeper down East hall. Resident #2 cket and exiting his room. d Staff A she was going to wer a call light and assumed and provide supervision of stated when she returned to her what had happened	F 60				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405055	B. WING		С		
		165355	B. WING			06/	15/2023
NAME OF PE	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 04 NORTH KEOKUK WASHINGTON ROAD		
KEOTA HEALTH CARE CENTER					EOTA, IA 52248		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677 SS=D	neither did, leaving ar to sexually abuse Rest to sexually abuse Rest According to an Intered dated 5/1/23 at 10:04 Nursing (DON), wrote aimlessly stating illogifragmented sentences saying No or striking cares or the direction Resident #1 wandere and was touched inapsigns of discomfort or ADL Care Provided for CFR(s): 483.24(a)(2) A resid	d supervise Resident #2 and n opportunity for Resident #2 sident #1. disciplinary Team (IDT) note a.m. The Director of Resident #1 wanders ical comments or s. Resident #1 will signal by out when she doesn't want she is lead. On the date d into Resident #2's room oppopriately, she showed no		600			
	services to maintain of personal and oral hygomersonal receive adequate sentheir personal hygienes ampled. Review of through June 15, 202 opportunities were proscheduled, however conce during that time address the resident's	good nutrition, grooming, and giene; is not met as evidenced ord review and staff failed to ensure residents vices (bathing) to maintain eneeds for 1 of 2 residents bathing records May 2023 3 found bathing ovided twice weekly as one resident refused all but period. The facility failed to se refusals leading to eds being unmet. (Resident					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED		
		165355	B. WING			C 06/15/2023	
NAME OF PI	ROVIDER OR SUPPLIER		ı	STREET ADDRESS, CITY, STATE, ZIP COL	DE	1 00/13	5/2025
KEOTA HE	KEOTA HEALTH CARE CENTER			204 NORTH KEOKUK WASHINGTON R	OAD		
			KEOTA, IA 52248				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 677	(MDS) with a reference #4 had a Brief Mental which indicated a most status. Resident #4 r with transfers, mobilit personal hygiene need included Non-Alzheim mellitus. According to Resident was scheduled to have and Saturdays. Review May 3, 2023 through Resident #4 with 13 of Resident #4 refused by the status of the status	erly Minimum Data Set ce date of 5/24/23, Resident I Status (BIMS) score of 8 derately impaired cognitive equired limited assistance y, dressing, toilet use and eds. Resident #4's diagnosis her's dementia and diabetes at #4's bathing records, she we baths on Wednesdays ew of shower records from June 14, 2023 noted opportunities to bath.	F	677			
F 689 SS=D	sometimes refused sl offer a diet soda or a her to bath. Review of entries in which these Free of Accident Haza CFR(s): 483.25(d)(1)(1)(1)(1)(2)(1)(2)(1)(2)(1)(2)(2)(1)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)		F	689			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		165355	B. WING _		0	C 6/15/2023
NAME OF PROVIDER OR SUPPLIER KEOTA HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248	•	0/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 689	facility failed to provide resident to prevent inwith other female resifacility reported censular facility reference date of 3/20 and long term memori impaired cognitive stain independent with transequired extensive as use and personal hygodiagnosis included All Non-Alzheimer's demand seizure disorder. According to a Minimizer ference date of 4/4/Mental Status (BIMS) moderately impaired face with the status and personal face for the status face of the status face of the status face of the status face of the rights and physically with arrow of the rights a door alarm with his doresident was exiting resident was exiting resident face of the status face	e adequate supervision of a appropriate sexual contact dents. (Resident #2) The is is 30. Important Set (MDS) with a 8/23, Resident #1 had short y deficits and a severely stus. Resident #1 was sfers and mobility, but sistance with dressing, toilet iene needs. Resident #1's zheimer's Disease, entia, renal insufficiency Important Set (MDS) with a 23, Resident #2 had a Brief score of 10 indicating a cognitive status. Resident sistance with transfers and e assistance with dressing, al hygiene needs. Resident ed schizophrenia, entia, diabetes mellitus and	F 6	89		

		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		С		
		165355	B. WING			06/	15/2023	
NAME OF PROVIDER	R OR SUPPLIER	•	•		TREET ADDRESS, CITY, STATE, ZIP CODE			
KEOTA HEALTH	CARE CENTER				4 NORTH KEOKUK WASHINGTON ROAD			
				K	EOTA, IA 52248			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
In an house Resid proces on his lobby was a going would plan of the strain and February was resident and February was resident and February was resident incident inc	ekeeper, stated lent #2's door a leded to his roo is jacket and state. Staff A shut of also present and to leave his root in provide Resident #2 with his lent #2 with his lent #1's breast of called out for Resident #2 were lesson for alarmicating supervisionar incident in whomen to the North hamed Staff A workision of Resident #2 was put om. Staff B state to the North hamed Staff A workision of Resident #2 was put on. Staff B state to the North hamed Staff A workision of Resident #2 was put on. Staff B state to the North hamed Staff A workision of Resident #2 was put on. Staff B state to the North hamed Staff A workision of Resident #2 was put on. Staff B state to the North hamed Staff A workision of Resident #2 was put on.	12/23 at 2:40 p.m. Staff A, on 4/29/23 she heard larm sound and she m. Resident #2 was putting ting he was going to the ff the alarm. Staff B, CNA d aware Resident #2 was om. Staff A assumed Staff B ent #2 supervision per his stated she left and went to she got a soda. Within d and noticed Resident #2's looked in to find Resident #1 her shirt pulled up and hands cupped over and his mouth over her Staff A stated she e the two, but Resident #2 ag to let go of Resident #1 assistance and Resident #1 e separated. Staff A stated ng Resident #2's door and has because of another ich Resident #2 was sexually nother female resident.	F	689				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		165355	B. WING _			C 06/15/2023	
NAME OF PROVIDER OR SUPPLIER KEOTA HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 204 NORTH KEOKUK WASHINGTON ROA KEOTA, IA 52248		00/13/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	both Staff A and Staff was going to stay and neither did, leaving ar to sexually abuse Research According to an interdated 5/1/23 at 10:04 Nursing (DON), wrote aimlessly stating illogifragmented sentences saying No or striking of cares or the direction Resident #1 wandere	ties root cause analysis, B thought the other person I supervise Resident #2 and n opportunity for Resident #2 sident #1. disciplinary team (IDT) note a.m. The Director of Resident #1 wanders ical comments or s. Resident #1 will signal by out when she doesn't want she is lead. On the date d into Resident #2's room oppopriately, she should no	F 6				