| 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 _____ | 01/23/2024 |

| 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<br><br>Correction Date:_____<br><br>The following deficiencies relates to the facility's Annual Health Survey completed on January 16, 2024 to January 23, 2024 and investigation of Facility Reported Incident #114589-I and Complaint #117062-C.<br><br>See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C. | F 000 | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still | F 578 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/06/2024

| 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 _____ | 01/23/2024 |

| 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 578 | Continued From page 1 | F 578 | | |

legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interviews, and facility policy the facility failed to implement advanced directives per resident and family directives upon admission for 1 of 3 residents reviewed and failed to clarify conflicting orders for 1 of 3 residents reviewed (Resident#5). The facility reported a census of 27 residents.

Findings include:

1. The Quarterly Minimum Data Set (MDS) dated 12/23/23 documented Resident #5 had the diagnoses including Diabetes Mellitus, stroke, and dementia. The MDS revealed the resident had a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment.

The Care Plan dated 12/6/23 directed staff in regards to the care of Resident #5 as follows;
a. Advanced Directives, the resident wishes to be Full Code.

| 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 _____ | 01/23/2024 |

| 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 578 | Continued From page 2 | F 578 | | |

b. Initiate transfer to the hospital of choice.
c. Maintain a copy of code status in the chart.

A Clinical Resident Profile documented the resident code status as full code, with initial admission date of 12/4/23.

The Iowa Physician Orders for Scope of Treatment (IPOST) dated 1/17/24 documented the resident's guardian requested the following;
a. Cardiopulmonary Resuscitation (CPR)
b. Full treatment under medical interventions
c. Long-term artificial nutrition by tube
c. The IPOST was signed by the residents provider

The Physician Orders for Resident #5 revealed:
a. On admission date 12/4/23 a Full Code order.
b. On date 12/8/23 a Do Not Resuscitate order.

2. The Admission MDS dated 10/10/23 documented Resident #13 had diagnoses including Parkinsons, and a BIMS score of 11 which indicated moderate cognitive impairment.

The Care Plan dated 11/28/23 for Resident #13 did not address Advanced Directives.

The residents' hard copy record review, and electronic record review Point Click Care (PCC) conducted on 1/16/24 at 1:27 p.m. lacked documentation of advanced directives for the staff to refer to for caring out the residents wishes.

The Physician Orders for Resident #13 lacked an order for Advanced Directives.

During an interview on 1/17/24 ay 8:51 a.m., The

| 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 _____ | 01/23/2024 |

| 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 578 | Continued From page 3<br>Director of Nursing (DON) stated she would expect the staff nurses to check the orders for code staff. The DON stated the DNR/Full Code may have been her fault as she wrote the DNR when Resident #5 first arrived.<br><br>During an interview on 1/17/24 at 12:26 p.m., Staff C, Advanced Registered Nurse Practioner (ARNP) stated on admission the orders were written for Advance Directives. Staff C stated it will be clarified today.<br><br>A Admission Agreement packet dated April 2022 provided to the survey team included an attachment G titled Advance Directive Policy and Record. The policy directive documented the following; It is the Provider ' s policy to recognize and implement the resident ' s rights under state law to make decisions concerning medical care, including the right to accept or refuse medical treatment, and the right to formulate Advance Directives. | F 578 | | |
| F 644 SS=D | Coordination of PASARR and Assessments<br>CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. | F 644 | | |

| 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 _____ | 01/23/2024 |

| 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 644 | Continued From page 4 | F 644 | | |

§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interviews the facility failed to ensure resubmission of the Preadmission Screening and Resident Review (PASRR) following new mental health diagnoses for 1 of 2 residents reviewed for PASRR (Resident #25). The facility reported a census of 27 residents.

Findings include:

The Admission Minimum Data Set (MDS) assessment dated 05/24/23 for Resident #25 documented diagnoses including, neurological conditions, diabetes, encephalopathy, hypokalemia, delirium due to known physiological condition. Did not include any diagnosis in the psychiatric, mood category. A Brief Interview for Mental Status (BIMS) assessment coded 5 out of 15 which indicated severe cognitive impairment.

The Quarterly, Minimum Data Set (MDS) assessment dated 11/16/23 for Resident #25 documented diagnoses including, orthopedic conditions, diabetes, delirium due to known physiological condition. Major depressive disorder, recurrent, unspecified was added and encephalopathy diagnosis had been removed. The MDS coded that antipsychotic medications were given during the last seven days and resident received on a routine basis. BIMS Score coded 7 out of 15 which indicated severe

| 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 _____ | 01/23/2024 |

| 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 644 | Continued From page 5 | F 644 | | |

cognitive impairment.

A PASRR dated 4/27/23 in the resident's Electronic Health Record (EHR) indicated no mental health conditions diagnosed or suspected now or in the past, no diagnosis of dementia or neurocognitive disorder. Primary medical condition for nursing facility care noted acute encephalopathy with attestation for psychiatric stability. PASRR document directed if changes occur a new screen must be submitted.

The Medication Record dated August 2023 indicated new order for antipsychotic medication Quetiapine 12.5 milligrams (mg) orally two times daily for mood, start date 8/18/23.

The Medication Record dated November 2023 indicated the medication, Quetiapine was increased from 12.5 mg to 25 mg on 11/22/23 related delirium due to known physiological condition and Major depressive disorder, recurrent, unspecified

The Medication Record dated January 2024 indicated the medication, Quetiapine continued to be given related delirium due to known physiological condition and major depressive disorder, recurrent, unspecified.

The Care Plan last revision on 1/10/24 included Resident #25 receives antidepressant, diuretic, antihypertensive and antidiabetic medication. The Care Plan did not address that the resident received an antipsychotic medication.

On 01/18/24 01:24 PM the Business Office Manager (BOM) reported she will be submitting for a new PASRR. The BOM stated the former

| 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 _____ | 01/23/2024 |

| 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 644 | Continued From page 6<br>social services and activities staff assisted with the PASRR's, and are no longer employed so may have been missed as a result, would look further into.<br><br>The facility provided the policy titled PASARR Policy last revised 11/2016 documented newly evident or possible serious mental disorders will be referred for appropriate services based upon their assessed needs, directed prompt notification after a significant change in mental or physical condition of resident who has mental disorder for review. | F 644 | | |
| F 655 SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a | F 655 | | |

| 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 _____ | 01/23/2024 |

| 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 655 | Continued From page 7 | F 655 | | |

comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews and policy review, the facility failed to complete a care plan within 48 hours of admission for one of one newly-admitted residents reviewed (Resident #25). The facility reported a census of 27 residents.

Finding include:

The Minimum Data Set (MDS) assessment dated 5/19/23 documented resident admitted to the nursing facility from the hospital on 05/19/23.

The initial Care plan dated 5/24/23 documented Resident #25 potential risk for altered nutritional status as evidenced by history of encephalopathy, confusion, diabetes, constipation, and obesity.

| 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 _____ | 01/23/2024 |

| 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 655 | Continued From page 8<br>The Care plan clinical electronic health record lacked any documentation of a baseline care plan being completed within 48 hours of the resident's admission to the facility to direct staff on resident care needs.<br><br>An Interview on 01/22/24 at 01:02 PM with the Business Office Manager (BOM) revealed a base line care plan could not be located in the clinical electronic record and was not in the resident's hard chart.<br><br>On 01/22/24 at 01:02 PM the Administrator relayed the base line care plan should be in the hard chart or the clinical electronic record. The Administrator acknowledged a base line care plan could not be located.<br><br>The facility policy titled Baseline Care Plans with last review date of 9/2024 directed staff as follows; a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. | F 655 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the | F 657 | | |

| 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 _____ | 01/23/2024 |

| 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 657 | Continued From page 9 | F 657 | | |

resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s).
An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility policy, and staff interviews, the facility failed to update a Care Plan to include antipsychotic medication for 1 of 5 resident's care plan reviewed for unnecessary medications (Resident #25). The facility reported a census of 27 residents.

Findings Include:

The Quarterly, Minimum Data Set (MDS) assessment dated 11/16/23 for Resident #25 documented diagnoses including, orthopedic conditions, diabetes, delirium due to known physiological condition. Major depressive disorder, recurrent, unspecified was added and encephalopathy diagnosis had been removed. The MDS coded that antipsychotic medications were given during the last seven days and resident received on a routine basis. BIMS Score coded 7 out of 15 which indicated severe cognitive impairment.

| 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 _____ | 01/23/2024 |

| 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 657 | Continued From page 10<br><br>The Care Plan last revised on 1/10/24 documented that Resident #25 received antidepressant, diuretic, antihypertensive and antidiabetic medication. The Care Plan did not address that the resident received an antipsychotic medication.<br><br>On 1/23/24 at 11:07 AM the Administrator acknowledged an antipsychotic medication should be documented on the Care Plan with interventions to alert staff of the expectations and related interventions.<br><br>The facility provided policy titled Comprehensive Care Plans, last revised 8/2022 documented, the comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS and physicians' orders. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. | F 657 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§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;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review and policy review, the facility failed to ensure resident is dry and free from odors for 1 of 3 reviewed for incontinent residents (Resident #3). The facility reported a census of 27.<br><br>Findings include: | F 677 | | |

| 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 _____ | 01/23/2024 |

| 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 677 | Continued From page 11 | F 677 | | |

The Quarterly Minimum Data Set (MDS) assessment tool, dated 12/21/23 listed diagnoses for Resident #3 which included medically complex conditions, cancer, heart disease, renal disease, dementia, malnutrition, anxiety, pulmonary disease. The MDS coded the resident for always incontinent of urine, revealed substantial and maximal assistance needed for toileting and hygiene. The Brief Interview for Mental Status (BIMS) assessment was not scored, which indicated the resident with cognitive impairment. The MDS document that the resident was rarely/never understood.

The Care Plan with revision date of 3/22/23 documented the following for Resident #3; incontinent of bladder with risks of skin integrity, falls and infection. The Care Plan interventions directed staff to clean peri-area with each incontinence, monitor and document for signs and symptoms of urinary tract infections that could include the following; pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns.

An Observation on 01/16/24 11:07 AM Resident #3 lying on sofa in his room wearing gray leisurely like elastic pants, wet in the groin area, strong urine odor.

An Observation on 1/17/24 at 09:02 AM Resident #3# lying on a sofa in his room, wearing jeans, wet in the groin area and thighs, strong odor urine present.

| 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 _____ | 01/23/2024 |

| 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 677 | Continued From page 12<br>An Observation on 1/18/24 at 8:55 AM Resident #3 lying on sofa in his room, dark blue pants are wet from the waist area to above the knees, strong odor of urine.<br><br>An Interview on 01/18/24 at 09:03 AM with the Administrator, entered resident #3 s' room, Resident #3 lying on his sofa. Administrator acknowledge resident pants were wet and a pool of liquid on the floor. The Administrator acknowledged resident's incontinence and acknowledged the odor of urine.<br><br>An Interview on 1/18/24 at 9:10 AM with Certified Nursing Assistant, Staff B reported the resident is often incontinent of urine, and he is not compliant with incontinent brief use. Staff B confirmed that the sofa in his room is soaked with urine, and acknowledged the strong urine odor. Administrator also present relayed the expectation of increased checking on the resident along with disposal of the urine-soaked sofa was needed.<br><br>The facility policy titled Urinary Continence and Incontinence, Assessment and Management, with last revision date of 11/2017 directed staff as follows; check and change strategy involved checking the resident's continence status at regular intervals and using incontinence devices or garments to maintain dignity and comfort and to protect the skin. | F 677 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental | F 758 | | |

| 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 _____ | 01/23/2024 |

| 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 758 | Continued From page 13 | F 758 | | |

processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

| 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 _____ | 01/23/2024 |

| 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 758 | Continued From page 14 | F 758 | | |

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, and policy review the facility failed to limit a As Needed (PRN) psychotropic medication to fourteen (14) day limit and failed ensure Gradual Dose Reduction (GDR) for 2 of 5 residents reviewed for unnecessary medications (Resident #15 & #25). The facility reported a census of 27 residents.

Findings include:

1. The Quarterly, Minimum Data Set (MDS) assessment dated 11/16/23 for Resident #25 included diagnoses, orthopedic conditions, diabetes, delirium due to known physiological condition and major depressive disorder, recurrent, unspecified. A Brief Interview for Mental Status (BIMS) assessment coded 7 out of 15 which indicated severe cognitive impairment

The Care Plan with last revision date of 1/10/24 documented that Resident #25 received antidepressant, diuretic, antihypertensive and antidiabetic medication. The Care Plan fail to address that the resident received a psychotropic medication.

The Medication Administration Record (MAR) dated January 2024 for Resident #25 documented an order for Lorazepam, give 0.25 milligrams(mg) orally every 4 hours as needed for comfort related to other nonspecific abnormal

| 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 _____ | 01/23/2024 |

| 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 758 | Continued From page 15 | F 758 | | |

findings of lung field with the start date of 12/29/23. The order reviewed on the January 23, 2023 reflecting 25 days in effect.

On 01/22/24 at 03:08 PM this surveyor requested to the Administrator and Business Office Manager (BOM) to provide documentation of physician review for approval to extend the psychotropic medication over fourteen (14 days). The BOM provided a written notation by the ARNP stated "continue" without rationale or date to continue the psychotropic medication.

On 1/23/24 at 11:07 AM the Administrator acknowledged the Advanced Registered Nurse Practitioner, (ARNP) Staff C should have reviewed PRN psychotropic medication in detail to included a resident review of Lorazepam that should have included the rationale for continuation along with a duration for the PRN order.

Facility policy titled Unnecessary Drugs revised 6/2023 documented, limit PRN orders for anti-depressants, hypnotics and anti-anxiety drugs to 14 days. This may be extended beyond the 14 days through documentation in the medical record by the practitioner as to why this should occur.

2. The Minimum Data Set (MDS) assessment dated 12-7-23 for Resident #15 included diagnoses, dementia, anxiety and psychotic disorder. A Brief Interview for Mental Status (BIMS) assessment was documented as not scored. The MDS coded the resident as rarely/never understood.

The Care Plan last updated on 1/16/24

| 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 _____ | 01/23/2024 |

| 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 758 | Continued From page 16 | F 758 | | |

documented Resident #15 received antipsychotic medications related to behavior management, disease process for dementia with behaviors, delusions and anxiety. Interventions included administering medications, pharmacy consult, Medical Doctor (MD) to consider dosage reduction when clinically appropriated, GDR per facility policy.

The Medication Administration Records (MAR) documented the following;

a. January MAR 2024 revealed Risperidone, 1 milligram, oral, two times a day related to dementia in other diseases classified elsewhere, unspecified severity, with behavioral disturbance start date 12/13/23.

b. December MAR 2023 revealed Risperidone, 1 milligram, oral, two times a day related to dementia in other diseases classified elsewhere, unspecified severity, with behavioral disturbance. Start date 8/4/23, discontinued date 12/13/23, Re-Start date 12/13/23, same dose, time change only.

c. August MAR 2022 revealed Risperidone, 1 milligram, two times a day related to dementia in other diseases classified elsewhere, unspecified severity, with behavioral disturbance. Start date 10/6/20 discontinued date 8/4/22 and restarted without missing doses, change to time to give only.

On 1/23/24 at 1:12 PM the Business Office Manager (BOM) reported they could not locate a pharmacy recommendation for gradual does reduction. She did email a pharmacy recommendation that Resident #15 have

| 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 _____ | 01/23/2024 |

| 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 758 | Continued From page 17<br>Abnormal Involuntary Movement Scale (AIM) testing while on Risperidone, no other documents found to support the GDR had occurred.<br><br>The facility policy titled Unnecessary Drugs revised 6/2023 documented and directed staff as follows;<br>1. Review the medication regime to identify the following drug classes, noted to be psychotropic:<br>a. Anti-psychotics;<br>b. Anti-depressants;<br>c. Anxiolytics; and<br>d. Hypnotics, including over the counter herbal and natural products.<br>2. Review the medication regime for the following types of medications which may be included in # 1, and apply appropriate clinical indications, monitoring and documentation:<br>a. CNS system agents;<br>b. Mood stabilizers;<br>c. Anticonvulsant's;<br>d. Muscle relaxants;<br>e. Anti-cholinergic medications;<br>f. Antihistamines; and<br>g. N-methyl-D-aspartate (NMDA) receptor modulators;<br>g. Gradual dose reductions will be conducted per CMS guidelines (Centers for Medicare/Medicaid services).<br>h. The facility shall elicit the Physician response and request documentation on the benefits of the medication outweighs the risks or suspected or confirmed adverse consequences. | F 758 | | |
| F 868 SS=D | QAA Committee<br>CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)<br><br>§483.75(g) Quality assessment and assurance.<br>§483.75(g) Quality assessment and assurance. | F 868 | | |

| 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 _____ | 01/23/2024 |

| 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 868 | Continued From page 18<br>§483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br>(i) The director of nursing services;<br>(ii) The Medical Director or his/her designee;<br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br>(iv) The infection preventionist.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.<br><br>§483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to employ a required Quality Assurance(QA) committee member, a qualified Infection Preventionist, to perform infection | F 868 | | |

| 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 _____ | 01/23/2024 |

| 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 868 | Continued From page 19 | F 868 | | |

control surveillance and report to the governing body, and the facility failed to conduct Quality Assurance and Performance Improvement (QAPI) meetings on a quarterly basis. The facility reported a census of 27 residents.

Findings Include:

The QAPI Plan dated 9/1/22 revealed:
a. QAPI meetings will be held no less than quarterly.
b. Staff members with the most knowledge and commitment to QAPI efforts will participate.

The Facility Assessment amended on date 1/3/23 listed Services and Care Offered Based on Resident Needs revealed infection prevention and control, identification and containment of infection and prevention of infections. This also included a Staffing Plan that revealed the facility worked to recruit and maintain appropriate staffing levels to meet the residents' needs. In the event of staff openings in the nursing department, nursing administration will be available to assure that all resident needs are met.

On 01/22/24 8:47 AM Staff A, RN and Infection Control Preventionist, reported she had taken the Centers for Disease Control (CDC), Infection Control Preventionist course but was unable to take the certification test. Completed documentation for a specialized staff Infection Preventionist was not available. Staff Staff A demonstrated a lack of understanding of information necessary to complete her duties as the facility Infection Preventionist. She indicated she took over the infection prevention role several months ago.

| 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 _____ | 01/23/2024 |

| 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 868 | Continued From page 20<br><br>On 01/22/24 10:47 AM The Human Resource Director stated infection control is not being done the way it should. Staff A took the course but got locked out so she was not able to take the test. The Human Resource Director stated that no staff was doing the tracking because no one wanted the job.<br><br>On 01/22/24 3:45 PM The Administrator reported she had concerns regarding the Infection Prevention and Control Program and the Antibiotic Stewardship Program. The Administer acknowledged the program had not been completed in several months. | F 868 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment | F 880 | | |

| 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 _____ | 01/23/2024 |

| 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 880 | Continued From page 21 | F 880 | | |

conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

| 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 _____ | 01/23/2024 |

| 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 880 | Continued From page 22 | F 880 | | |

infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to implement an infection control surveillance plan to identify, track, monitor and report infections. The facility failed to provide documented evidence from February 2023 through January 2024 for an infection control surveillance program. The facility reported a census of 27 residents.

The findings include:

The facility provided a document titled Monthly Surveillance Report dated January 2023 which revealed:
A Urinary Tract Infection (UTI) treated with an antibiotic.
An eye infection

The facility provided 3 documents titled Anti-infectives for Keota Healthcare Center revealed:
Dated 2/1/23 to 2/28/23 listed a resident name and medication.
Dated 3/1/23 to 3/31/23 listed 2 residents and 4 medications.
Dated 4/1/23 to 4/30/23 listed 4 residents and 5 medications.
Lacked evidence of surveillance for February, March and April 2023.

The Facility Assessment amended on date 1/3/23 listed Services and Care Offered Based on

| 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 _____ | 01/23/2024 |

| 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 880 | Continued From page 23 | F 880 | | |

Resident Needs revealed infection prevention and control, identification and containment of infection and prevention of infections. This also included a Staffing Plan that revealed the facility worked to recruit and maintain appropriate staffing levels to meet the residents' needs. In the event of staff openings in the nursing department, nursing administration will be available to assure that all resident needs are met.

On 01/22/24 8:47 AM Staff A, RN and Infection Control Preventionist, reported she had taken the Centers for Disease Control (CDC), Infection Control Preventionist course but was unable to take the certification test. Completed documentation for a specialized staff Infection Preventionist was not available. Staff Staff A demonstrated a lack of understanding of information necessary to complete her duties as the facility Infection Preventionist. She indicated she took over the infection prevention role several months ago.

On 01/22/24 10:47 AM The Human Resource Director stated the infection control was not being done the way it should. Staff A took the course but got locked out so she was not able to take the test. The Human Resource Director stated that no staff was doing the tracking because no one wanted the job.

On 01/22/24 3:45 PM The Administrator reported she had concerns regarding the Infection Prevention and Control Program and the Antibiotic Stewardship Program. The Administer acknowledged the program had not been completed in several months.

| 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 _____ | 01/23/2024 |

| 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 881 | Continued From page 24 | F 881 | | |
| F 881 SS=E | Antibiotic Stewardship Program<br>CFR(s): 483.80(a)(3)<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of facility policy, facility document review or lack of, and staff interviews the facility failed to maintain an Infection Prevention and Control Program (ICPC) that included a functional Antibiotic Stewardship Program. The failure to have a system in place that monitors antibiotic use in accordance with established protocols has the potential to affect all 27 residents of the facility.<br><br>Findings Include:<br><br>Review of a policy provided by the facility titled "Antibiotic Stewardship" revised October 2018, documented antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents. Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic | F 881 | | |

| 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 _____ | 01/23/2024 |

| 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 881 | Continued From page 25 | F 881 | | |

stewardship.

1. Review of Resident # 2 Electronic Medical Record (EMR) indicated the resident was diagnosed with Chronic kidney Disease, Stage 4 (Severe), squamous cell carcinoma of skin of other parts of the face and type 2 diabetes mellitus without complications.

Review of Resident #2 EMR titled Administration Record, Medication Administration Record (MAR) resident #2 was administered Clindamycin capsule (CAP) 300 mg Give 1 capsule orally every 6 hours for skin infection for 7 days. Medication was administered from 1/13/24 to 1/20/24.

2. The facility failed to produce a monthly Infection Control Report or a monthly Antibiotic Stewardship log and a system for identifying clusters of infections in the facility for the time period since April 2023. An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor was not provided.

On 01/22/24 8:47 AM Staff A, RN and Infection Control Preventionist, reported she had taken the Centers for Disease Control (CDC), Infection Control Preventionist course but was unable to take the certification test. Completed documentation for a specialized staff Infection Preventionist was not available. Staff Staff A demonstrated a lack of understanding of information necessary to complete her duties as the facility Infection Preventionist. She indicated she took over the infection prevention role several months ago.

On 01/22/24 10:47 AM The Human Resource

| 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 _____ | 01/23/2024 |

| 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 881 | Continued From page 26<br>Director advised infection control was not being done the way it should. Staff A took the course but got locked out so she was not able to take the test. The director advised Staff A agreed to take over the Infection Control program task but it was not getting done. The director shared no one is really doing it because no one wanted to take it over.<br><br>On 01/22/24 3:45 PM The Administrator reported she had concerns regarding the Infection Prevention and Control Program and the Antibiotic Stewardship Program. The Administer acknowledged the program had not been completed in several months.<br><br>On 01/23/24 The facility was unable to produce any data pertaining to the antibiotic stewardship program since April 2023. | F 881 | | |
| F 882 SS=E | Infection Preventionist Qualifications/Role<br>CFR(s): 483.80(b)(1)-(4)<br><br>§483.80(b) Infection preventionist<br>The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must:<br><br>§483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;<br><br>§483.80(b)(2) Be qualified by education, training, experience or certification;<br><br>§483.80(b)(3) Work at least part-time at the facility; and | F 882 | | |

| 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 _____ | 01/23/2024 |

| 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 882 | Continued From page 27 | F 882 | | |

§483.80(b)(4) Have completed specialized training in infection prevention and control.
This REQUIREMENT is not met as evidenced by:
Based on policy review and staff interviews the facility failed to provide an Infection Preventionist with specialized training or certification to monitor and provide oversight for the facility's Infection Prevention and Control Program. The facility reported a census of 27 residents.

Findings include:

The policy, titled Infection Control Policy and Procedure Manual, OBRA regulations and Interpretive Guidelines page 35, revised 08/2017, documented the facility Infection Preventionist is responsible for the facility's infection prevention and control program.

On 01/22/24 8:47 AM Staff A, RN and Infection Control Preventionist, reported she had taken the Centers for Disease Control (CDC), Infection Control Preventionist course but was unable to take the certification test. Completed documentation for a specialized staff Infection Preventionist was not available. Staff Staff A demonstrated a lack of understanding of information necessary to complete her duties as the facility Infection Preventionist. She indicated she took over the infection prevention role several months ago.

On 01/22/24 10:47 AM The Human Resource Director reported infection control is not being done the way it should. Staff A took the course but got locked out so she was not able to take the test. The director advised Staff A agreed to take over the Infection Control program task but it was

| 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 _____ | 01/23/2024 |

| 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 882 | Continued From page 28<br>not getting done. The director shared no one is really doing it because no one wanted to take it over.<br><br>On 01/22/24 3:45 PM The Administrator advised she had concerns regarding the Infection Prevention and Control Program and the Antibiotic Stewardship Program. The Administer acknowledged the program had not been completed in several months.<br><br>On 01/23/24 The facility was unable to produce any data that indicated a certified Infection Preventionist was employed at the facility. | F 882 | | |