STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165396	A. BUILDING _____ B. WING _____	09/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVER HILLS VILLAGE IN KEOKUK	20 VILLAGE CIRCLE KEOKUK, IA 52632

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents received medications as ordered for 1 of 19 sampled (Resident #13). The facility reported a census of 57 residents. Findings include: 1. The Minimum Data Set (MDS) assessment, dated 1/8/20, listed [DIAGNOSES REDACTED]. The MDS stated the resident required limited assistance of 1 staff for eating, extensive assistance of 2 staff for bed mobility, transfers, dressing, toilet use, and personal hygiene, and depended completely on 2 staff for bathing. The MDS listed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 7, indicating severely impaired cognition. The January Medication Administration History listed a 1/2/20 order for Nudexa (medication of pseudobulbar affect) 10-20 milligrams (mg) twice daily. The record showed the resident did not receive the medication on 1/19/20 and 1/20/20 and instead received [MEDICATION NAME] (medication for congestion) 600 mg twice daily. The facility policy Pharmaceutical Procedures, dated 10/18/19, stated the facility would provide residents with only the necessary medication for their health needs. During an interview on 8/19/20 at 1:43 p.m., the Director of Nursing (DON) stated the resident's supply of Nudexa ran out and they needed insurance approval for this. She stated she was not in the building to assist with completing this so the physician changed the medication to [MEDICATION NAME]. The DON stated the [MEDICATION NAME] was not appropriate for the resident's [DIAGNOSES REDACTED]. She stated the resident began taking the Nudexa again after they obtained another order for it. She stated the facility now must call her if this happened again so she could obtain medications.
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to provide the necessary services to maintain good nutrition, grooming, personal and oral hygiene for 7 of 16 sampled. Concerns with incontinence care for Resident's #1 and #4, concerns with oral hygiene for Resident's #1, #2, #3 and #4, and concerns with personal hygiene for Resident's #6, #7 and #8. The facility reported a census of 57. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had [DIAGNOSES REDACTED]. Resident #1 had severe cognitive impairments with symptoms of [MEDICAL CONDITION] present, rarely or never able to make self understood or understood others, and required extensive assistance by at least 1 staff to reposition in bed, transfer to and from bed and chair, personal hygiene, dressing, eating, bathing and toilet use, unable to ambulate, always incontinent of bowel and a urinary catheter in place at that time. A nursing care plan directed staff to provide total oral care and incontinence care. Observations revealed: On 8/18/20 at 6:02 a.m., Resident #1 in bed with the overhead lights off. On 8/18/20 at 6:28 a.m., a Nurse Aide entered Resident #1's room followed by another Nurse Aide with a mechanical lift. At 6:33 a.m., Resident #1 dressed and seated in a wheel chair with her hair brushed. A cup in the bathroom contained a tube of tooth paste dated 6/7/20 with the resident's initials on it and a dry tooth brush, and full bottle of mouth wash. On 8/18/20 at 11:41 a.m., Staff A (Nurse Aide) Staff B (Nurse Aide) removed Resident #1's wet brief and provided incontinence care. The staff failed to cleanse both hips. At 11:48 a.m., the staff transferred Resident #1 to a wheel chair and transported to the dining room. The staff failed to provide oral care. Resident #1's tooth brush remained dry. On 8/19/20 at 6:39 a.m., Resident #1 dressed and seated in a wheel chair in her room. No change of oral care products in the bathroom with the resident's initials, tooth brush remained dry. On 8/19/20 at 10:04 a.m., Resident #1 in bed, tooth brush remained dry in cup in bathroom. At 2:24 p.m., Resident #1 in bed, tooth brush dry, mouth wash bottle full. On 8/20/20 at 6:58 a.m., Resident #1 dressed and seated in a wheel chair in the dining area, an unlabeled denture cup in the bathroom contained a scant amount of blue liquid the same color as the mouth wash with approximately 2 to 3 ounces removed from the full level, the tooth brush remained dry and tooth paste without change of appearance. 2. The MDS assessment dated [DATE] documented Resident #4 had [DIAGNOSES REDACTED]. Resident #4 had severe cognitive impairments. Resident #4 required extensive assistance of at least 1 staff to reposition in bed, transfer to and from bed and chair, personal hygiene, dressing, eating, bathing and toilet use, unable to walk, and always incontinent of bowel and bladder. The nursing care plan directed staff to provide incontinence care and oral care and had dentures. Observation on 8/19/20 from 7:16 a.m. to 7:31 a.m., revealed Staff C (Nurse Aide) and Staff D (Nurse Aide) removed Resident #4's wet brief and provided incontinence care. The staff failed to cleanse both hips. Staff C then cleansed Resident #4's dentures in the bathroom. Staff C placed the dentures in Resident #4's mouth and failed to offer or provide oral hygiene care. 3. The MDS assessment dated [DATE] documented Resident #2 had [DIAGNOSES REDACTED]. Resident #3 required extensive assistance of 1 staff to reposition in bed, transfer to and from bed and chair, personal hygiene, dressing, bathing and toilet use, and unable to ambulate. The nursing care plan directed staff to encourage Resident #2 to turn from side to side or scoot up/down or sit up on side of bed with assistance of side rails, transfer to a power wheel chair with a mechanical lift, and the resident independent once in the wheel chair. Observations revealed: On 8/18/20 at 6:03 a.m., Resident #2 positioned in bed on back, the head of the bed up but resident had slid down in the bed, her head tilted to her left, the top of her head against the mattress of the elevated HOB. On 8/18/20 at 9:45 a.m., remained on back in bed, head tilted to her left, asleep. Two cups in the bathroom held tooth brushes and tooth paste, tooth paste in 1 of the cups labeled with the room-mate's name, the remaining items unlabeled, and approximately 31 to 32 ounces remained in a 33 ounce size bottle of mouth wash labeled with the resident's name. On 8/18/20, the resident remained on back in bed when observed at 10:34 a.m., 11:07 a.m., 11:38 a.m. and 1:41 p.m., the tooth brushes in the bathroom remained dry. On 8/19/20 at 7:05 a.m., resident on back in bed with her head leaned to the left, asleep. The tooth brushes in the bathroom remained dry, and no change of level in mouthwash container. On 8/19/20 at 9:47 a.m., the resident remained on back in bed with head of bed elevated as a therapist worked at the bedside. At 10:56 a.m., the resident remained on back in bed, awake, stated staff usually got her up to the wheel chair 1 or 2 times a day, she had not been up for 2 days when she had a shower, staff did not assist her with oral care when she was in bed, she could complete most of her personal hygiene when positioned in the wheel chair by the sink with some staff assistance. On 8/19/20 at 2:26 p.m., resident on back in bed, appeared asleep, tooth brushes remained dry. On 8/20/20 at 6:59 a.m., resident on back in bed, appeared asleep, tooth brushes remained dry and without evident use, no change of amount of mouth wash in he container. 4. The MDS assessment dated [DATE] documented Resident #3 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Care Plan directed staff to encourage the resident to turn from side to side, or scoot up/down or sit up on side of bed with side rails and staff assistance, transfer with mechanical lift, encourage resident to self-propel in wheel chair with rest periods. Observations revealed: On 8/18/20 at 6:58 a.m., resident dressed, seated in wheel chair, hair appeared combed. The resident had a room mate who was also up at the time. One cup in the bathroom to the left side of the since contained a small pair of fingernail clippers, a tube of tooth past with indications a small amount had been used, and a dry toothbrush, all unlabeled, and no

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

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) other oral care products evident. On 8/19/20 at 7:59 a.m., resident on back in bed with HOB elevated, awake. The resident stated it was uncomfortable for her to sit in the wheel chair and unable to get close to the bathroom sink when in the wheel chair, staff had not assisted her with oral hygiene and she used the napkin form her meals to wipe off her dentures. The tooth brush remained dry and no changes of tooth paste amount observed. At 9:28 a.m., remained on back in bed, HOB somewhat lowered, appeared asleep, tooth brush remained dry. A perineal Care policy dated as last revised 11/2018 directed staff to cleanse the perineal area with soap and water, perineal cleanser or wipes, cleanse from the cleanest area in front to the most soiled area in back, and use a clean surface of the cloth for each wipe. Staff interviews revealed: On 8/19/20 at 7:36 a.m., Staff D (Nurse Aide) stated staff should assist or provide personal hygiene care to resident's that required assistance every morning and when needed, and staff could refer to the computer where they document cares if they did not know what care or assistance the resident needed, or could also ask the nurse about the resident's care requirements. During an interview on 8/20/20 at 7:20 a.m., the Director of Nurses stated she expected staff to provide oral hygiene care and brush the resident's teeth in the morning and evening, if dentures used they were also to be cleaned in a denture cup in the morning and evening and staff to use a tooth brush or toothette to clean the resident's gums/oral cavity, tooth brushes replaced monthly on the 1st and as needed, and all oral care supplies should be labeled with the resident's initials. When staff completed incontinence care she expected them to change gloves at appropriate intervals, change gloves after they handles clothing or a soiled brief, wipe from front to back and change the surface of the cloth with each wipe. 5. The MDS assessment dated [DATE] listed [DIAGNOSES REDACTED]. The MDS stated the resident required supervision and setup assistance for transfers, walking, dressing, eating, toilet use, and personal hygiene, and extensive assistance of 1 staff member for bathing. Resident #6 had severely impaired cognition. During an observation on 8/19/20 at 7:50 a.m., Resident #6 sat at the breakfast table with other residents in the dining room. A large tuft of Resident #6's hair stuck up in back. 6. The MDS assessment dated [DATE] listed [DIAGNOSES REDACTED]. The MDS stated the resident required supervision assistance for transfers, walking, dressing, eating, and toilet use, limited assistance of 1 staff for personal hygiene, and extensive assistance of 1 staff member for bathing. The MDS listed the resident's BIMS score as 3 out of 15, indicating severely impaired cognition. During an observation on 8/19/20 at 7:50 a.m., Resident #7 sat at the breakfast table with other residents in the dining room. The resident's hair was disheveled. A care plan entry, dated 8/27/20, stated the resident required staff supervision with grooming. 7. The MDS assessment dated [DATE] listed [DIAGNOSES REDACTED]. The MDS stated the resident required supervision and setup assistance for transfers, walking, dressing, eating, toilet use, and personal hygiene, and extensive assistance of 1 staff member for bathing. The MDS listed the resident's BIMS score as 8 out of 15, indicating moderately impaired cognition. During an observation on 8/19/20 at 7:50 a.m., Resident #8 sat at the breakfast table with other residents in the dining room. The resident's hair was disheveled. A care plan entry, dated 4/15/20, stated the resident required assistance with grooming. The facility policy Personal Care of Residents, dated 12/03, stated staff would assist residents with grooming including hair care. During an interview on 8/20/20 at 7:20 a.m., the Director of Nursing stated she expected staff to brush and fix residents hair.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to assess and intervene when a resident had a change of condition for 1 of 19 sampled (Resident #13). The facility reported a census of 57. Findings include: 1. The Minimum Data Set assessment dated [DATE] listed [DIAGNOSES REDACTED]. Resident #13 required limited assistance of 1 staff for eating, extensive assistance of 2 staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #13 had a Brief Interview for Mental Status score of 7 out of 15, indicating severely impaired cognition. The Progress Note dated 2/25/20 at 9:00 p.m. revealed Resident #13's tongue very dry with raised brown patches. The staff faxed the physician for further orders/recommendations. The Clinical Record lacked documentation of further action taken related to Resident #13's dry mouth and lacked documentation of fluid intakes for Resident #13 throughout her stay at the facility. The Progress Note dated 3/1/20 at 12:44 p.m. revealed Resident #13 lethargic, had respirations slightly labored at 32 breaths/minute(normal 12-16 breaths/minute), pulse 125 beats/minute(normal 60-100 beats/minute), and course lung sounds. The facility contacted the Physician who ordered to send Resident #13 to the emergency room . A Hospital Nursing Assessment Form dated 3/1/20 at 1:35 p.m. documented Resident #13's mouth very dry and scaly. A Hospital Emergency Physician note dated 3/1/20 at 3:00 p.m., documented Resident #13 had dry mucous membranes and listed clinical impressions of dehydration, [MEDICAL CONDITION] (a high concentration of sodium in the blood), and hypovolemia (a low volume of circulating blood in the body). A Hospital Laboratory report dated 3/1/20 documented Resident #13 gad a sodium level of 168 millimoles- per liter. A normal range considered 136 to 145. The Care Plan entry dated 1/7/20 documented Resident #13 at risk for dehydration due to diuretic use and directed staff to encourage fluids, monitor for symptoms of dehydration such as dry skin, dry mouth, and dry mucous membranes, and to monitor labs. During a telephone interview on 9/9/20 at 8:30 a.m., the Director of Nurses (DON) stated they did not keep any records of food or fluid intake for Resident #13. She stated she would look for follow-up to the mouth bumps. During a telephone interview on 9/9/20 at 11:14 a.m., the DON stated she did not see any follow up for Resident #13's dry mouth and tongue. She stated an expectation of staff to follow up and notify the physician. During an interview on 9/14/20 at 2:41 p.m., Staff H (Family Nurse Practitioner) stated Resident #13 had a really high sodium and significantly dehydrated at the hospital.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to carry out assessments consistent with professional standards of practice to promote healing of a pressure ulcer for 1 of 5 sampled (Resident #12). The facility reported a census of 57. Findings include: 1. The Minimum Data Set assessment dated [DATE] listed [DIAGNOSES REDACTED]. The MDS revealed Resident #12 required extensive assistance of 2 staff for bed mobility, transfers, and toilet use. Resident #12 had a Brief Interview for Mental Status score of 12 out of 15, indicating moderately impaired cognition. Resident #12 had 1 - Stage II (partial thickness skin loss) pressure ulcer and 1 - unstageable pressure ulcer. According to the Face Sheet Resident #12 admitted to the facility on [DATE]. The Braden Scale for Predicting Pressure assessment dated [DATE] revealed Resident #12 had a moderate risk for developing a pressure ulcer. A Progress Note dated 3/17/20 documented Resident #12 had a Stage II pressure area on the left side of the coccyx measuring 4 centimeters (cm) by 3 cm. A Skin Integrity Events document dated 3/18/20 documented Resident #12 had a right heel deep tissue pressure injury. A Progress Note dated 3/25/20 revealed a new order for Collagen powder to the buttock and cover with a border dressing. A Physical Therapy Daily Treatment Note dated 3/30/20 documented Resident #12 had wounds on both buttocks. The March 2020 Treatment Administration History directed staff to cleanse the pressure area on the coccyx with wound cleanser and cover with a border dressing from 3/17/20-3/26/20. The record directed staff to apply a Collagen powder to the coccyx and cover with a border dressing from 3/25/20-3/31/20. The record directed staff to monitor the deep tissue injury to the right heel. The Clinical Record lacked further assessments of the coccyx wound and heel wound including measurements from admit on 3/17/20 until discharge on [DATE]. The Clinical Record lacked documentation of more than 1 open area on Resident #12's buttocks. A Progress Note dated 3/31/20 at documented Resident #13 discharged home. The Care Plan entries dated 3/18/20 documented Resident #12 at risk for pressure ulcers and directed staff to utilize side rails to assist with turning and positioning and to complete skin treatments and therapy as ordered. The Care Plan failed to indicate Resident #12 had an actual pressure area and interventions to prevent further ulcers from developing and promote healing of existing ulcers. The Wound Care policy revised 03/04 directed staff to document the status of wounds no less than once per week. During an interview on 8/19/20 at 1:43 p.m., the Director of Nurses stated Resident #12's coccyx wound was not improving and they changed the treatment. The Director of Nurses stated an expectation of the Nurses to measure and assess the wounds weekly.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to follow infection control guidelines for 3 of 19 sampled (Residents #1, #4, and #5). The facility reported a census of 57. Findings include: 1. During an observation on 8/19/20 at 7:35 a.m., Staff G (Licensed Practical Nurse) removed a glucometer from the medication cart and placed it on

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) Resident #5's bedside table without a barrier and without disinfecting the table. Staff G obtained Resident #5's blood glucose level twice and then placed the glucometer in the drawer of the medication cart without a barrier. Staff G removed the glucometer from the medication cart and disinfected it with a wipe. The Glucose Monitoring policy revised 11/15, directed staff to disinfect the glucometer between uses. During an interview on 8/20/20 at 7:20 a.m., the Director of Nurses stated an expectation of staff to sanitize the glucometer with a disinfectant wipe prior to placing it in the medication cart. 2. The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #1 had [DIAGNOSES REDACTED]. Resident #1 had severe cognitive impairments and [MEDICAL CONDITION]. Resident #1 required extensive assistance of 1 staff for positioning, personal hygiene, dressing, eating, bathing and toilet use. Resident #1 had bowel incontinence and a urinary catheter. The Care Plan directed staff to provide incontinence care. During an observation on 8/18/20 at 11:41 a.m., Staff A (Nurse Aide) and Staff B (Nurse Aide) removed Resident #1's wet brief. Staff A placed the wet brief on the bed and with the same gloved hands removed disposable wipes from a container and placed them on the bed without a barrier. Staff A used the wipes placed on the bed without a barrier to cleansed Resident #1's anterior perineal area. Staff B positioned on the opposite side of the bed held Resident #1 on her side as Staff A cleansed the posterior perineal area with the same gloved hands. A Perineal Care policy revised 11/2018 directed staff to expose the perineal area, wash hands and apply gloves, cleanse the perineal area with soap and water, perineal cleanser or wipes, cleanse from the cleanest area in front to the most soiled area in back, and use a clean surface of the cloth for each wipe. During an interview on 8/20/20 at 7:20 a.m., the Director of Nurses (DON) stated an expectation of staff to to change gloves at appropriate intervals, change gloves after they handles clothing or a soiled brief, wipe from front to back and change the surface of the cloth with each wipe when they provided incontinence care.